

DOEPA AFTER DARK:  
PROTECTIVE MEDICINES FOR INFANTS IN SOWETO, SOUTH AFRICA

By

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## TABLE OF CONTENTS

	<u>page</u>
ACKNOWLEDGMENTS .....	ii
LIST OF TABLES .....	viii
LIST OF FIGURES .....	ix
ABSTRACT .....	x
 CHAPTERS	
1. INTRODUCTION .....	1
 <b>PART I THEORETICAL AND HISTORICAL</b>	
2. PHARMACEUTICAL PRODUCTS AND THE THIRD WORLD .....	9
Introduction .....	9
World Health Organization and Pharmaceuticals .....	12
Limited Success in Implementing WHO Suggestions .....	14
Summary of Problems with Pharmaceutical Products .....	17
Criteria for Drug Choice .....	24
South Africa's National Drugs Policy .....	24
Summary .....	25
3. PHARMACEUTICAL ANTHROPOLOGY AND THE STUDY OF MEDICINE ..	27
Introduction: The Need for Local Perspectives .....	27
Anthropology and the Study of Pharmaceuticals: An Exotic Bias?. ...	29
Research Themes in Pharmaceutical Anthropology .....	30
The Meaning of Medicines .....	35
Indigenisation of Medicines .....	41
Summary .....	41



4.	DUTCH MEDICINES: FROM GERMANY FOR SOUTH AFRICA .....	42
	Introduction .....	42
	Spices and Drugs in Europe .....	43
	Humoral Medicine .....	45
	Medicines at the Cape .....	47
	Huis-apotheek .....	49
	Dutch Medicine from Halle, Germany .....	51
	What Is in a Name? .....	52
	Pamphlets .....	54
	Mixing Medicines .....	56
	Summary .....	56
 <b>PART II      METHODOLOGICAL</b>		
5.	INTRODUCTION TO SOWETO AND THE SAMPLE .....	57
	Introduction .....	57
	Historical Background .....	58
	The People and the Characteristics of the Research Sample .....	61
	Summary .....	72
6.	RESEARCH DESIGN AND METHODS .....	73
	Types of Data Collected .....	73
	Literature Survey .....	74
	Informal Discussions .....	75
	Observation .....	76
	Sampling .....	78
	Interviews .....	78
	Study documents .....	81
 <b>PART III      ETHNOGRAPHIC</b>		
7.	PROTECTING VULNERABLE INFANTS: SUMMARY OF AFRICAN HEALTH AND HEALING CONCEPTS IN SOUTH AFRICA .....	82
	Introduction .....	82
	Humans and Their Environment .....	84
	Supreme Being .....	88
	Ancestors .....	88
	Sorcery or Witchcraft .....	89
	Pollution Beliefs .....	91
	Protecting Infants .....	94
	Summary .....	104

8.	<b>DIBOTLOLO TSA BANA: DUTCH REMEDIES FOR SOWETO INFANTS</b>	
	Introduction .....	106
	Types of Dutch Medicines Used in Soweto .....	108
	Mixing and Combining Dutch Medicines in Soweto .....	120
	Conditions Dutch Medicines Are Used for and Why They Will Help ..	123
	Protection and Strengthening of the Baby .....	124
	How to Achieve Total Protection .....	133
	Side Effects .....	135
	Source of Knowledge .....	136
	Source of Medicine .....	137
	Doepa .....	138
	Types of <i>Doepa</i> .....	141
	<i>Doepa</i> Use in Soweto .....	142
	Summary .....	148
9.	<b>MUTI WENYONI: MEDICINE FOR A SUNKEN FONTANELLE</b> .....	149
	Introduction .....	149
	<i>Muti Wenyoni</i> and a Sunken Fontanelle .....	150
	Soweto Mothers and <i>Muti Wenyoni</i> .....	154
	So What Is Wrong with Supply and Demand? .....	157
	Diarrhea and Dehydration .....	158
	Diarrhea and Oral Rehydration Therapy .....	159
	<i>Muti Wenyoni</i> : Discussion .....	160
 <b>PART IV      POLICY IMPLICATIONS</b>		
10.	<b>CONCLUSION: IMPLICATIONS FOR COMMUNITY HEALTH AND HEALTH PROMOTION</b> .....	163
 <b>APPENDICES</b>		
A	<b>QUESTIONNAIRE</b> .....	170
B	<b>FIVE EXAMPLES OF MEDICINE BOXES OF DUTCH MEDICINES</b> .....	175
C	<b>PACKAGE INSERTS OF DUTCH MEDICINES</b> .....	180
D	<b>MEDICINE BOXES AND TRANSLATIONS OF <i>MUTI WENYONI</i></b> .....	197
E	<b>MEDICINE INSERTS OF <i>MUTI WENYONI</i></b> .....	208

GLOSSARY .....	217
REFERENCES .....	220
BIOGRAPHICAL SKETCH .....	231

## LIST OF TABLES

<u>Table</u>	<u>page</u>
1. Mother's education .....	69
2. Place where the infant's mother grew up .....	70
3. Number of pregnancies .....	70
4. Number of live births .....	71
5. Infants' ages .....	71
6. Length of time babies should be kept indoors .....	99
7. Nineteen different types of Dutch medicines are used by the Soweto sample .	109
8. Reasons for using Dutch medicines .....	123
9. The ways <i>Doepa</i> and/or <i>Imphepho</i> are used .....	147

## LIST OF FIGURES

<u>Figure</u>	<u>page</u>
1. Soweto map .....	62
2. Women in the Soweto sample's first language .....	63
3. Description of seven yards in Soweto .....	66
4. Example of seven yards in Soweto .....	67
5. Percentages of the Soweto sample that use one or more Dutch medicines . . .	108
6. Percentages of the 11 most popular Dutch medicines used by the sample . . .	110
7. Number of Dutch medicines used at a time .....	120
8. Reasons for using Dutch medicines .....	124
9. Frequency of using Dutch medicines for the child .....	135
10. Kinds of precautions necessary with giving Dutch medicines to the child . . . .	136
11. Person who encouraged mother to use Dutch medicines .....	137
12. Descriptions of <i>Doepa-olie</i> in two different Dutch medicines' pamphlets . . . .	141
13. Percentage of <i>Doepa</i> and/or <i>Imphepho</i> users .....	143
14. Reasons provided by the Soweto sample for using <i>Doepa</i> and/or <i>Imphepho</i> . .	144
15. Muti Wenyon use by Soweto sample .....	154
16. Reasons for using Muti Wenyon .....	155

Abstract of Dissertation Presented to the Graduate School  
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Pharmaceutical products have swamped the Third World during the past 30 years. An incredible selection of prescription and over-the-counter pharmaceuticals is currently available and used in Africa, Asia and Latin America. The extensive use of pharmaceutical products by people in the Third World has become an increasing concern for international health organizations because many of the products are ineffective, unnecessary and a waste of resources. Ironically, there is often a lack of the most needed (essential) drugs in these areas. Although no one will deny that pharmaceutical products, when used well, can play a vital role in improving the health of people, it should be emphasized that medicines cannot replace a basic infrastructure to sustain health or an adequate healthy food supply, sanitation or a clean water supply.

Since the 1980s anthropologists report that many biomedical products replace age-old local herbal remedies and that people have reinterpreted pharmaceuticals in terms of

local cultural concepts, giving new meaning to products. This is also true for South Africa. An array of over-the-counter products is, for example, specifically aimed at the African infant market. This study focused on two groups of these over-the-counter medicines (*Muti Wenyoni* and Dutch Medicines). In Soweto we interviewed a random sample of 211 mothers with infants of 12 months or younger on their use of these over-the-counter medicines.

Eighty one percent of mothers used from one to ten different Dutch medicines regularly and 49% used *Muti Wenyoni* to soothe fretful infants and/or protect them from illness and misfortune. The medicines are administered to babies in one or more of the following ways: orally, added to bath water and/or smeared on the “vulnerable” parts of the body. *Doepa* is specifically burned at night to calm babies and keep bad spirits away.

The Dutch Medicines, almost 200 years in use in South Africa, represent an excellent example of the process of indigenisation of pharmaceutical products. Originally from Europe these medicines have constantly been reinterpreted by different groups to suit South African conditions and local folk healing traditions. *Muti Wenyoni* is an example of how the pharmaceutical industry can exploit local ideas about health and illness to manufacture and sell a product. Several different manufacturers of antacids use variations of the indigenous illness concept *inyoni* (associated with green diarrhea and a sunken fontanel) as part of their product's name, and some of them specifically refer to the indigenous concept of a specific childhood illness on the medicine covers.

## CHAPTER 1 INTRODUCTION

Pharmaceutical<sup>1</sup> products have swamped the Third World during the past 30 years. The result is an incredible selection of prescription and over-the-counter (OTC) pharmaceuticals are currently available and used in Africa, Asia and Latin America. Although there are local pharmaceutical industries in many Third World countries, most of the available products are manufactured by Western multinationals who "tend to manufacture medications designed to meet the health needs of populations in the developed countries, rather than poorer countries" (Ferguson in Helman 1996:218). In this context, large quantities of expensive medications are being exported to the Third World, often accompanied by advertising campaigns which emphasize products' advantages over indigenous remedies and locally produced pharmaceuticals (Helman 1996:218).

No one will deny that pharmaceutical products, when used well, can play a vital role in improving the health of people, especially in the developing parts of the world, but the solution is not to pour tons of expensive, ineffective and often unsafe, drugs at the problem<sup>2</sup>. In addition to this, the pharmaceutical industry often over-stresses the value of

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<sup>1</sup>A pharmaceutical or pharmaceutical product is a commercially manufactured biomedicine.

<sup>2</sup>Large quantities of inappropriate and sometimes expired medicines are being sent as humanitarian donations to regions of conflict. For example, the World Health Organization estimated that 45% of all the donations received in 1994 in Zagreb were either worthless or expired (Purvis 1996:39).



its products as a panacea for all ills (Chetley 1990:14-15). It cannot be emphasized enough that medicines cannot replace a basic infrastructure to sustain health or replace an adequate healthy food supply, sanitation, or a clean water supply.

The complex situation that developed in Third World<sup>3</sup> countries during the last few decades as a result of the unlimited access to Western pharmaceuticals took most researchers by surprise. The general public moved with great comfort between biomedicine and indigenous medicine, choosing either or both. Reports of self-medication with all kinds of medicines<sup>4</sup> as the rule, not the exception, began to mount as over-the-counter and prescription medicines became available in large quantities in the informal sector and were being traded on the streets and in shops by people without any formal training in their appropriate use. Also, many indigenous healers began to incorporate pharmaceutical products into their repertoire of treatments. In South Africa, for example, African healers not only sell herbs, bulbs and bark, but they also sell pharmaceutical products aimed at the African market such as different kinds of *Imbiza*<sup>5</sup>. Pharmaceutical products are also added to indigenous remedies. I observed how a healer in Marquard in the Free State Province added crushed Aspirin to one of his medicine mixtures.

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<sup>3</sup>The focus on the Third World does not suggest that the problems with pharmaceutical products are not present in the rest of the world and that essential drugs and rational drug use policies are not needed everywhere.

<sup>4</sup>Pharmaceutical products, pharmaceuticals, medicines and drugs are used interchangeably in the literature. I follow that practice in this dissertation when referring to pharmaceutical products and will refer to *indigenous or herbal* medicine where necessary.

<sup>5</sup>*Imbiza* is a collective term for purgatives associated with internal cleansing used amongst other things for blood purification, fertility problems, chest complaints (Varga and Veale 1997:914). For example *Imbiza Yempilo* (Blood Mixture) by Impilo Drugs.

Although anthropologists were always aware of the symbolic meaning of medicines, it was not until the 1980s that they began to actively concentrate on the social and cultural aspects of modern pharmaceutical products (Van der Geest, Whyte and Hardon 1996:154). Because of what Whyte and Van der Geest (1988:9-10) call the "exotic bias", many anthropologists overlooked the impact of pharmaceuticals on local healing traditions. It was indeed Van der Geest and other anthropologists associated with the University of Amsterdam and the Royal Tropical Institute in Amsterdam who had done most of the early anthropological research on pharmaceutical products. Their interest was fueled by observations that increasingly popular biomedical products often replaced age-old local herbal remedies and that people reinterpreted pharmaceuticals in terms of local cultural concepts, giving them new meaning. Concomitantly, many pharmaceutical products were promoted and sold under "traditional medicine" labels<sup>6</sup>, using indigenous names for the products. For example, in South Africa, a little black "herbal" bag hung around a child's neck is sold as a "traditional herbal comforter for children" under the name *Izinyamazane Zabantwana*<sup>6</sup> by Natal Herb Suppliers.

During the 1970s and 1980s, several serious critiques of the "pharmaceutical invasion" of the Third World were published. This led the World Health Organization (WHO) to respond with the concept of essential drugs--the need to have a limited number of inexpensive and safe drugs available for common diseases. The organization later introduced the concept of rational drug use with the emphasis on responsible prescription and use of medicines.

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<sup>6</sup>*Izinyamazane* means wild animal poisons. *Zabantwana* means for children.

South Africa has a large number of local and international pharmaceutical manufacturers and experiences many of the same problems that beset the rest of the Third World. Although not so well documented, there is enough evidence of the same popularity of pharmaceutical products, especially over-the-counter products for self-medication. Over-the-counter medicines are widely available in South Africa, from the shelves of pharmacies and large retail stores to the cupboards of small neighborhood *spazas*<sup>7</sup>, as well as on the tables of streets vendors<sup>8</sup> in every town and city. Most of the OTC products are manufactured in South Africa, by multinational subsidiaries or local pharmaceutical companies, by a number of small companies that specialize in "African Medicine" or "*Muti*<sup>9</sup> Medicine", as well as fly-by-night backyard manufacturers. The pharmacies, shops and tables of streets vendors in the central business district of Johannesburg are testimony to this variety. There are also a number of Muti Shops around Johannesburg and Soweto selling indigenous medicines (including pharmaceutical products marketed as indigenous). They include the infamous Mai-Mai store in Jeppe, Johannesburg. The most popular medicines sold to adult African customers are laxatives, purgatives and various potency enhancers. Many of the products use African names that

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<sup>7</sup>Small informal neighborhood shops , usually a room in a house, a garage or a small room next to the house.

<sup>8</sup>I bought a \$5 sealed plastic bottle called "African Mixture for All Diseases, Herbalist" from a street vendor. Printed on the side of bottle, in English, Zulu and Sotho, were the list of problems it could cure: Air filled intestines, pig lice, drop, poison, arthritis, discharging penis, gall, sterility, bladder, swelling feet, fear, body pains, cramps, unpleasant body smell and high blood pressure!

<sup>9</sup>*Muti* means medicine. *Umuthi* (pl *imithi*) is used as synonym for medicine although it has a much wider connotation (Ngubane 1977:22).

refer to indigenous herbal products, for example *isihlambezo*<sup>10</sup>, or use indigenous concepts on the product labels, for example *imbiza*.

An array of so-called *African or Muti* medicines and other OTC products are specifically aimed at the African infant market. The most popular medicines for infants can be categorized into "soothers" (for example gripe waters and certain antacids) and "protectors", medicines to ward off illness and/or to ensure continuing health (for example, various kinds of Dutch Medicines that will be discussed in Chapters 8).

Many of the medicines aimed at the African market belong to the category "old medicines"<sup>11</sup>. Pharmaceutical products in South Africa are regulated by the Medicines and Related Substances Control Act, No 101 of 1965. The so-called "old medicines" that existed before 1965, are permitted the right of sale until the South African Medicines Control Council (MCC) wants to examine them. Towards the end of 1990, the MCC began to actively evaluate different medicine categories including thousands of "old medicines" that were sold without ever having gone through a formal evaluation. Categories of medicines (for example antacids) were "called up" and manufacturers were asked to submit formal applications. The application for each medicine has to conform to MCC regulations and Act 101 of 1965 in terms of active ingredients, preservatives, package insert, labeling and name. The MCC has also issued directives on "Misleading and

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<sup>10</sup>Companies specializing in African Medicine sell a product by the name of *isihlambezo*. The main ingredients in this pharmaceutical product are iron supplements and vitamin B12. Traditionally women used the herbal extraction *isihlambezo* prescribed by indigenous healers to "promote a favourable course of pregnancy and facilitate quick uncomplicated labor (Varga and Veale 1997:914). Varga and Veale (1997:915) also note that nurses in the rural clinic where they conducted some of their research "often referred to antenatal iron supplements as *isihlambezo*."

<sup>11</sup>Medicines in existence before the Medicines and Related Substances Control Act, No 101 of 1965.

Inappropriate Proprietary Names of Medicines" (Medicines Control Council 1996b Medicines Control Council 1997) and the "Alcohol Content of Medicines for Oral Ingestion" (Medicines Control Council 1996a).

With a few exceptions, self-medication with pharmaceutical products has not received any attention by South African anthropologists. The OTC products that infants receive is a vastly under researched area with the potential of making an important contribution to our knowledge and understanding of the use of these medicines in a South African context. It also has the potential to impact health promotion efforts and public health policy.

In 1982 ,while working for the Department of Health in the eastern part of the Free State Province, and again in 1993 during a study of early infant practices in Soweto, I noticed that a large number of mothers used over-the-counter medicines for their infants. Both Muti Wenyon and Dutch Medicines were frequently mentioned.

In this dissertation I focus specifically on these two groups of over-the-counter medicines (*Muti Wenyon* and Dutch Medicine) which are used to soothe fretful infants and/or protect them from illness and misfortune. Both groups of medicines are used for "self-medication" by primary caretakers of small infants without the advice of an expert, be that a bio-medical professional or an indigenous healer.

The Dutch Medicines, almost 200 years in use in South Africa, represent an excellent example of the process of indigenisation of pharmaceutical products. Originally from Europe these medicines have constantly been reinterpreted by different groups to suit South African conditions and local folk healing traditions. For example, African mothers in Soweto use anywhere from 1 to 10 different types of Dutch Medicines at a time for their infants. These different types of Dutch medicines are being reinterpreted to fit African

concepts of health and illness and given new meanings that have nothing to do with what the medicines are actually intended for.

*Muti Wenyoni* is an example of how the pharmaceutical industry can exploit local ideas about health and illness to manufacture and sell a product. Several different manufacturers of antacids use variations of the indigenous illness concept *inyoni*<sup>12</sup> as part of their product's name, and some of them specifically refer to the indigenous concept of this childhood illness on the labels of their products. In reality, *inyoni* is associated with serious diarrhea and dehydration. Although diarrhea is not a big problem in Soweto, it is in other parts of South Africa where the product *Muti Wenyoni* is also available and used.

The data for this study were collected from the end of 1994 to the beginning of 1997 in the larger Johannesburg metropole. The specific focus was on Soweto where we interviewed 211 caretakers of children aged 1 year old or younger on their use of these OTC medicines. I also used archival material, such as user pamphlets and advertisements, to explore the origins of the medicines, as well as changes in the medicines and their use over time. In addition, I examined package material and user inserts from the different medicines.

In Chapter 2 of this dissertation I outline the problems with pharmaceutical products in the Third World, while I discuss the scope of pharmaceutical anthropology, as well as the indigenisation and reinterpretation of pharmaceuticals in Chapter 3. In Chapter 4 I outline the historical context of Dutch medicines. Chapter 5 describes the study

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<sup>12</sup>Literally means bird in Zulu, but is also symbolically used for a serious childhood illness. This condition known as *Inyoni* is explained as a life threatening condition where a "snake" or a "worm" is eating the child's "insides". Green stools are also associated with this condition. If untreated, *inyoni* leads to a sunken fontanelle and ultimately the child's death (see Chapters 6, 8 and 9).

methodology. The study location and the sample are introduced in Chapter 6. Chapter 7 outlines the underlying beliefs about health and illness in South Africa with specific reference to African infants. In Chapters 8 and 9 I present the study results on Dutch Medicine and *Muti Wenyoni*. In Chapter 10, I discuss the implications of this study for health promotion and public health policy.

## CHAPTER 2 PHARMACEUTICAL PRODUCTS AND THE THIRD WORLD

### Introduction

Prior to the Second World War most people in developing countries had very little access to modern medicines. Health care was limited to home remedies, indigenous healers and the occasional missionary hospital.

The last 30 years brought about dramatic changes in access to bio-medicine and most parts of the world witnessed a massive commodification of health care services and medicines. These changes and their effect on the developing world have not always been recognized by researchers. Foster warns us that "the extent to which traditional peoples today opt for scientific medicine is...not fully appreciated by anthropologists" (Foster 1984:848). As an example of the impact of bio-medicine on indigenous healing systems Foster (1984:849) quotes a study by Bhatia et al. in India which found that 90% of the Indigenous Medical Practitioners use bio-medicine to some degree as part of their treatment regimes and that most of them have thermometers, syringes, needles and stethoscopes. In Mauritius biomedicine, rather than herbal medicine, is the treatment of choice for most illnesses (Sussman 1988:208). And a study by Ferguson in Asunción, El Salvador, concludes that the dependence on modern brand name pharmaceutical products "has altered local health care traditions and the means of coping with illness that were previously common in the community, drained away resources without providing any



long-term improvement in living conditions, and actually caused illness" (Ferguson 1988:40). This trend is generally true for Africa and certainly for South Africa.

Others, such as Feierman and Janzen (1992) blame the artificial dichotomy *Western* versus *traditional* for blinding us from seeing that people in various parts of Africa perceive a diverse set of options for treatment and therefore use bio-medicine and indigenous medicine interchangeably. Because most of the past literature on African healing therapies presented the healers' point of view the perception was created that healing practices fit into frameworks, neatly organized into hierarchies of causality. As soon as researchers included the patient's point of view, it became clear that healing therapies are constantly changing, actively adapting and incorporating new ideas and strategies to deal with a changing world, changing cultures and new diseases (Feierman and Janzen 1992). It also became clear that healing therapies easily expand across cultural boundaries. It is therefore not surprising that Western pharmaceutical products are readily incorporated into local healing traditions, often taking the place of traditional remedies. This argument is supported by Nichter and Vuckovic (1994:1510) who point out that "in today's world there is an increasing number of contexts in which multiple therapy systems and pharmaceutical resources coexist and eclectic forms of treatment, experimentation and improvisation are engaged".

Health care became more and more commodified since WW II as "health" became increasingly something to be bought and sold (Chetley 1990:10-11). People began to see health as something you can achieve and maintain by consuming a variety of pharmaceutical products, be they antibiotics or vitamin pills. Helman argues that commodification and medicalization go hand in hand:

...the massive inflow of pharmaceuticals into Third World countries contributes towards a gradual 'medicalization' of ill-health and suffering: moving away from more social, holistic or indigenous approaches to illness, toward an emphasis on only one form of therapy - drug treatment (Helman 1996:219).

One of the implications of the commodification of health is that the focus of health care is turned on "technical fixes to health problems" as a solution rather than to have to address "basic problems of distribution within highly stratified societies" (Reeler 1996:135). The easiest of those "technical fixes" is swallowing a pill or taking an injection. The status of many medicines has become so elevated that some pharmaceutical brand names achieved the same status during the late 20<sup>th</sup> century as clothing brand names. This is ultimately symbolized by the new trend of wearing a silver or gold designer Prozac around your neck.

Not only have pharmaceutical products achieved a high status<sup>13</sup> and become easily accessible in the developing world, but pharmaceuticals are increasingly being used in very different ways than originally intended. In addition, many products are deliberately marketed to conform to local ideas about illness and treatment.

In this chapter I examine the influx of pharmaceutical products in the Third World in general, and problems associated with this, and look at the various issues raised by critics. Criticism points in many directions: the pharmaceutical industry and their practices; national governments' policies and regulations; prescribers and suppliers of medicines; and consumers and their behavior. I describe the WHO's response to the perceived crisis and discuss some of the problems with implementing their recommendations. In the end

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<sup>13</sup>Milk of Magnesia, for example, is a precious gift to a new born child in Ghana (Van der Geest and Whyte 1989:351)

it becomes clear that there are many general criticisms of pharmaceutical products, but few case studies to illustrate the problems. As Van der Geest rightly points out in his 1987 article, there is a desperate need for "local perspectives". This means that we urgently need more information on local situations, local practices and local experiences. Examples of how anthropologists have begun to address this will be discussed Chapter 3.

### World Health Organization and Pharmaceuticals

As early as 1962 the World Health Assembly urged the World Health Organization and national governments to pay more attention to the control of drugs (Chetley 1990:22). But it was only in the late 1970s that the WHO took the lead in suggesting new international drug policies. Their main argument centered around the large number of unnecessary drugs available in the Third World, versus the shortage of badly needed medicines. The WHO further pointed out that the growing reliance on imported ineffective drugs and their inappropriate use in the Third World will have serious long term public health consequences: taking drugs may reduce symptoms but will do nothing about the underlying causes of diseases (Muller 1982; Melrose 1983).

In 1977 the WHO proposed an Action Program for Essential Drugs<sup>14</sup> (APED) to deal with the drug supply situation. The proposed essential drugs list contained about 250 essential drugs (chosen from tens of thousands) that should be available to every population and were deemed as essential for maintaining health. The main objective of the

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<sup>14</sup>Essential drugs are drugs that are required to treat the majority of conditions that are prevalent in a country in a cost-effective and efficient manner. The concept does not imply that no other drugs are useful, but that these are the most needed for health care of the majority of the population. They should therefore be available at all times, in adequate amounts and in the proper dosage forms" (Department of Health 1996:4).

APED was "to strengthen national capabilities of developing countries in the selection, procurement and distribution and the proper use of essential drugs to meet the health needs of the majority of the population" (Report on the International Conference on Social and Cultural Aspects of Pharmaceuticals 1991:1). The philosophy behind the WHO's program is summed up as:

to achieve health objectives, provision for the basic requirements of food, clean water and sanitation is top priority. The major diseases for which preventive or curative strategies are needed are diarrhoeal diseases, acute respiratory infections, malaria, tuberculosis and sexually transmitted diseases. The Essential Drugs Concept evolved as a means of planning, identifying, quantifying and establishing structures for providing essential drugs needed to treat the majority of these illnesses (A Strategy Paper 1995:5-6).

The WHO's recommendations are therefore in line with the Alma Ata declaration of 1978. This declaration defined health as a state of complete physical, mental and social well-being of the individual and not merely the absence of disease (Reeler 1996:130). At this groundbreaking conference the concept of Primary Health Care which stressed self-help and prevention of health problems in a community context rather than bio-medical dependency was introduced (Arundel et al. 1990:3). The essential drugs concept became part of the Primary Health Care concept and therefore part of the WHO's drive for Health for All by 2000. In this context drugs are viewed as a tool to improve health but also a potential problem if not used appropriately.

It was a logical step for the essential drugs list to be followed-up by policy recommendations in 1981 about the rational<sup>15</sup> use of drugs. The concept of rational use

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<sup>15</sup>It is not always clear what is meant by the concept "rational". What people understand under "rational" depends on the social and cultural context. Policy recommendations incorporating the idea of rationality need to specify what they mean by the use of the term.

of drugs: "requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements for an adequate period of time, and at the lowest cost to them and their community" (Suleman 1997:474).

In the 1980s the WHO redefined their general objective about drugs to:

to ensure the regular supply to all people of safe and effective drugs of acceptable quality and lowest possible cost, in order to reach the overall objective of Health for All by the year 2000 through health systems based on primary health care (BUKO Pharma Kampagne 1987:5).

The WHO recommendations are not easy to follow. Some of the Nordic countries came closest to this ideal with their comprehensive licensing laws for drugs. Norway, for example, allows only 730 active ingredients legally, and "drugs are not licensed for use if they offer no real gain; and are also quickly removed from the market if they lose an advantage they once had" (Medawar 1984:34).

### **Limited Success in Implementing WHO Suggestions**

By the mid 1990s the WHO recognized that their essential drugs program had only achieved limited success. Failures were common, especially in the Third World, and could be attributed to a multitude of factors. Problems often "are related to the fact that the pharmaceutical field is typically characterized by the presence of strong vested interests, including trade, industry, health professionals and sometimes government agencies" (A Strategy Paper 1995:11). Also, the WHO has very little influence over the large private market (Editors 1995:2). In Bangladesh, for example, strong opposition by Transnational Pharmaceutical Companies and private doctors almost destroyed the National Drugs Policy in the early 1990s (Strategy Paper 1995:11).

To implement any of the WHO policy recommendations, the pharmaceutical industry, governments, prescribers and consumers have to be involved, committed, and motivated for change. However, to get congruence between the different interest groups depends on many factors.

## **Government**

National Drugs Policies are very dependent on the commitment from government, and the main stakeholders such as medical doctors and pharmacists. Ideally governments should be the driving force in the formulation and implementation of drug policies but many Third World governments have weak national drug regulations and control, and they often lack the political will to enforce existing policies. In general, legislation, infrastructure and the means of implementing policies are still poorly developed in most countries (A Strategy Paper 1995:7). Different countries also have big variations in regulations and laws. Many countries find it difficult to control pharmaceutical products:

... in some Third World countries, up to 75 per cent of the drugs moving in the market may be outside the control of health ministries. This highly unsatisfactory situation may have become even more serious during the last few years of extensive deregulation (Editors 1995:2).

## **Pharmaceutical Industry**

The cooperation of the pharmaceutical industry is also needed to implement and execute any National Drug Policies. They should commit themselves to the National Policies, be open and transparent, and practice effective self-regulation. There is an urgent need for the industry to take stewardship of their products - in other words, take responsibility for the entire cycle of a product from the manufacturing to its end effect.

## Prescribers

Health professionals such as medical doctors, pharmacists and nurses need to be "knowledgeable and skillful in the wise use and delivery of drugs" since they can make or break National Drug Policies (A Strategy Paper 1995:19). Poor prescribing practices enhance the risk of treatment failure or injury and the potential efficacy of medicines. Unfortunately, many health professionals lack training in rational drug use management.

In India, for example, prescribers often benefit from the poor regulation of non-essential drugs. Nichter and Vuckovic (1994:1517) conclude that:

proprietary drugs marketed as 'traditional' offer much higher profit margins than do essential drugs. When the former drugs are marketed in a manner that makes them appear to be modern (by name and packaging), they are doubly attractive to dispensing doctors. These drugs enable practitioners to reap financial rewards and simultaneously appear to be scientific yet appreciative of traditional health wisdom (Nichter and Vuckovic 1994:1517).

In their study of a rural Ghanaian town Wolf-Gould and co-researchers found that pharmacists often contribute to the inappropriate use of drugs by providing drugs according to popular demand.

The source of advice to use a drug had little effect on correct knowledge of drug use. Although the hospital based health care workers tended to prescribe correctly, the transfer of information was impeded by time constraints and cultural or language barriers. Thus, patients were left to rely on popular beliefs about the drugs they were given. Chemists dispensed in accordance with popular beliefs about drugs existent in the community despite any correct knowledge they might have. By default these popular beliefs emerge as the most powerful influence on drug use by individuals (1991:87).

## Consumers

Finally, the way in which consumers use drugs is the real measure of the success of any drug policy. To get consumers involved in understanding appropriate drug use is

usually done in a top-down fashion and does not involve understanding the consumers' perspective. It would be, for example, important to understand consumers' attitudes and practices such as the criteria employed in making decisions about which medicine to use and for what purpose. Objective information about drugs is scarce in the Third World and consumer education is urgently needed (A Strategy Paper 1995:6-7). Consumers generally get little information about medicines and how to use them, and health educators are often only concerned with "telling people" what is good for them, not really involving the consumer in the process (Medawar 1984:38).

A consumer guide by the international action group Health Action International sums up the problems with users of pharmaceutical products in 1986:

What makes a drug a problem is not so much its inherent pharmacological risks, but the way in which it is used. It is impossible to talk about the 'safety' of medicines as if it was a laboratory problem. In the wrong hands or at the wrong time, even the most carefully quality-controlled medicine becomes transformed from a life-saver to a life-threatener (Van der Geest 1987b:273).

### **Summary of Problems with Pharmaceutical Products**

The first systematic criticism of the international pharmaceutical industry in the Third World was Mike Muller's book "The Health of Nations" in 1982. His focus is on the way in which pharmaceutical companies do business in the Third World that leads to the inappropriate use of medicines. The consequences of this misuse are drug resistance and wasting of scarce resources. Many others followed him with similar and additional criticisms in the 1980s. Although many of the critics are guilty of making general statements without providing examples, the issues they raise are relevant for this study. The main problems and arguments of these critics can be summarized as follows.



## **Lack of Essential Drugs**

Almost every writer on pharmaceuticals in the Third World agrees that there is an urgent need for essential drugs instead of what we currently find: a situation with too many drugs available that offer no or very little benefit to their users. Medawar (1984:4) argues that up to 70% of the pharmaceutical products on the market are 'inessential' and/or undesirable. A strongly worded statement in Development Dialogue sums up the situation:

Today, 20 years after the Essential Drugs Concept (EDC) was formulated at the international level, 17 years after the 'Health for All' declaration was made at Alma Ata, and 10 years after the Nairobi Conference on the Rational Use of Drugs was held, some 2.5 billion people, or one-half of the world's population, continue to be denied their right to health and lack secure access to essential medicines (Editors 1995:5).

## **Focus on Curative Not Preventative Medicines**

The availability and encouragement to use medicines, leads people to believe that all their health problems can easily be solved by just taking another pill or having another injection. As Nichter and Vuckovic (1994:1512) pointed out "Pharmaceutical fixes of diseases often constitute the path of least resistance in the context of underdevelopment, a strategy whereby health promotion eclipses health protection". There is a growing tendency all over the world to rely on treatment of disease rather than to focus on its prevention. This trend has serious consequences for Primary Health Care programs which try to move away from a curative approach.

## **Waste of Resources**

Researchers disagree on the strain that imported pharmaceutical products put on local economies (Yudkin 1978:810; Smith 1983:1; Taylor 1986:1144). Nevertheless, there

are many indications of high costs for governments that have to spend scarce resources on expensive medicines. Whether governments are wasting money or not, it is at least clear that large numbers of individuals spend their limited resources<sup>16</sup> on expensive medicines that will "do them no good, and may cause them harm, and many may contribute to antibiotic resistance in human pathogens" (Trostle 1996:1117). Because drugs are being promoted under brand names and brand loyalty is being encouraged, people tend to shy away from the cheaper generic medicine (Medawar 1984:22).

### **Ineffective and Dangerous Products**

Many pharmaceutical companies are accused of promoting and selling products that are not very helpful. Criticism is especially focused on over-the-counter products for self-limiting diseases such as colds and most kinds of diarrhea. Further criticism is aimed at the misuse of antibiotics for these self-limiting diseases. The resistance to antimicrobial agents is currently a global problem and mostly the result of the misuse of antimicrobial drugs. Ironically, people often have to try and find drugs, at additional cost, that particular bacteria are not resistant to. Over-the-counter drugs are not always as safe as people would like to believe and taking these products is not without risks. However, the main risks are not necessarily associated with the active ingredients but usually with the way in which they are prescribed and used (Chetley 1988:4).

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<sup>16</sup>In a nutrition study by the Medical Research Council in a poor Cape Town area, women listed over-the-counter medicines at the top of their monthly expenditures (Leslie Bourne Medical Research Council of South Africa 1997 personal communication).

## Irrational Combinations

Groups like Health Action International compile lists of medicines whose active ingredients represent "irrational" combinations. For example, cold and cough mixtures which contain an ingredient to encourage cough as well as an ingredient to suppress the cough (Chetley 1988:4).

## Over-medication

The power and prestige of bio-medicine often leads to unnecessary and excessive medicine taking which creates all kinds of problems such as the over-dependence on drugs. An additional problem associated with over-medication is that medicines can be used "to mask behaviours as well as symptoms. Problematic behaviour, such as the crying of a fussy child, can be 'corrected' by medicating the child with alcohol- or opium-based medicines" (Nichter and Vuckovic 1994:1511). Many of the OTC medicines used for children have sedating ingredients for example antihistamine or alcohol that encourage drowsiness and sleep (Gadomski 1994:1063). Informal conversations with South African women led me to believe that "drugging" children is a common practice - dipping the child's pacifier in alcohol, giving Woodward's Gripe Water<sup>17</sup> by teaspoon or giving the child Panado Paediatric Syrup<sup>18</sup>. I will present examples in Chapter 8 from the interviews with

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<sup>17</sup>Each 5 ml contain Sodium bicarbonate 50 mg, Terpeneless Dill Oil 2.15 mg, Nipasept Na 0.1% m/v and Alcohol 3.5% v/v.

<sup>18</sup>A popular pediatric syrup where each 5 ml contains Paracetamol 120 mg, Methylparaben 0.1% m/v and Ethanol 10%v/v.

the Soweto mothers that they "*mudrugga*" (drug) the child with Dutch medicines, many of which contain more than 50% v/v alcohol<sup>19</sup>, opium tincture and valerian.

### Side-effects and Poisoning

Although package inserts commonly warn against side-effects, consumers in the Third World are often unaware of it because they are illiterate, cannot understand the language used in the insert, do not read the inserts, or buy medicines without the inserts. In addition, there are many reports of children being poisoned by taking medicines after unscrewing the top. Although there is a drive for child resistant bottle tops in South Africa many companies are reluctant to do that because of the additional cost.

### Promotion and Misleading Consumers Information

The pharmaceutical industry with their vested interests and emphasis on profits are accused of overemphasizing the usefulness of medicines and are often accused of misleading advertising. Chetley (1988:5) quotes a former Abbott and Ciba-Geigy executive saying that prescription drugs are promoted "as if they were candy or cosmetics". Besides being accused of false or misleading promotion, companies are also faulted for promoting the idea of "a pill for every ill", in addition to a tendency to medicalize every human emotion and all life events. Osifo (1983) provides many examples of the over-promotion of pharmaceutical products in Nigeria in an article in which he compares package inserts of similar products from the United States and Nigeria. He comes to the

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<sup>19</sup>In a Medicines Control Council circular of July 1996 all medicines must comply with the new standards of alcohol levels by 31 July 1999. The maximum for ethyl alcohol for children under 6 years of age is 0.5 v/v (Medicines Control Council 1996a).

conclusion that the weak drug control regulations in many developing countries are exploited by companies to make strong promotional statements in their product package inserts.

Although producers and manufacturers can contribute a lot to our understanding of pharmaceutical products they also reinforce many misconceptions and misunderstandings about drugs. The benefits of medicines are often over-estimated "partly because their advantages are over-stressed and partly because their disadvantages are unknown and unrecognized" (Medawar 1984:23).

An editorial note in Development Dialogue sums up the critique:

What makes the situation so serious is that the intensive marketing of pharmaceutical products has diluted the comprehensive concept of health to such an extent that for many people health now equals 'Doctor + Medicine' or just 'Medicine', irrespective of safety, price or quality. In the context of the new philosophy that is spreading all too rapidly, concern for basic factors such as nutrition, clean water and sanitation as the pillars of good health seems to be lost in the remote distance (Editors 1995:2).

### **Prescription and Inappropriate Use**

What makes drug use problematic is both the way in which it is prescribed and the way in which it is used. People often see pharmaceuticals as a miracle solution to their problems and engage in very dangerous and inappropriate forms of self-medication.

### **Starting a Habit of a Life Time**

The most severe criticism is reserved for medicines for children. Most of the common childhood illnesses are not very serious and usually self-limiting or can be easily prevented through immunization programs, proper nutrition, access to safe water and a clean environment. Mild infections help to build up a child's immune system against

common diseases. In this context the question should be asked if children really need the many medicines that are targeted at them. This is especially true for all the OTC medicines for children. Researchers agree that too many medicines are given to babies and children and according to the WHO "two-thirds of all drugs used by children may have little or no value" (Chetley 1988:12). There are many potential dangers to children with the inappropriate use of drugs. More than 12% of in-patients in a Mexican children's hospital monitored from 1983 to 1988 experienced adverse effects to the medication they received before coming to the hospital. In 1988 in the USA 2% of more than 6500 pediatric admissions were due to adverse drug reactions (Chetley 1988:12).

People forget that children's bodies react differently to medicines than the bodies of adults. The way children respond can only be determined through research and experience. In spite of this, many drugs do not have different dosages indicated for children and adults. In the USA, although about 75% of drugs are either contraindicated or have strong precautions for the use in children and nine out of ten warn against the use for toddlers and infants, children are often targeted for drug therapy, especially for the use of OTC medicines for problems such as diarrhea, cold and coughs. There is a lot of pressure on parents, especially on mothers, or other prescribers, to use pharmaceutical products.

The WHO points out that the inappropriate use of drugs for children has both immediate and long term consequences. For the present, the waste of resources and the potential for unnecessary adverse reactions are both strong arguments to encourage more care in prescribing of drugs for children. But the unknown psychological and social consequences for children of excessive and inappropriate drug use is a worry for the future as well. 'Children may tend to grow up believing that drugs are the solution to many of life's problems' (Chetley 1988:19).

### Criteria for Drug Choice

After all these criticisms the question remains how could anybody feel safe taking medicines and how could public policies address the problem of selecting medicines.

The WHO makes some suggestions that essential drugs should be available and accessible to everyone, and when properly prescribed and used they could be a powerful, although limited, tool to improve health. The criteria for selection of basic drugs should also take into account the local health needs and priorities, as well as levels of training of health care workers. Researchers (Medawar 1984:34; Chetley 1990) agree that the main criteria that should be used to distinguish between more or less acceptable products should be:

- a. if it is unnecessary - it should meet a real medical need
- b. if an alternative is safer
- c. if the ingredients are of little proven value - efficacy
- d. if the product is poorly formulated - quality
- e. if there is strong evidence of inappropriate use
- f. if the product offers poor therapeutic value for money.

### South Africa's National Drugs Policy

Much has been written about the disparities of South Africa's apartheid health care system prior to 1994 (De Beer 1986; Wilson and Ramphele 1989). Private health care, funded by medical aid schemes, provided services to about 20% of the population (mostly white), while a highly fragmented public sector (at least 14 health authorities) covered the rest of South Africans. Problems in the public health care sector are reproduced in the pharmaceutical sector where the biggest problems are high drug prices, the lack of

essential drugs for the poorer sections of the population, and the irrational use of medicine; all with negative consequences for the quality of health care.

South Africa has never focused on policy issues regarding the pharmaceutical sector in a systematic way until the African National Congress' (ANC) National Health Plan for South Africa (1994) and specifically the 1996 National Drug Policy document of the new Department of National Health. This National Drug Policy will be part of the National Health Policy which aims at "equity in the provision of health for all" and has as its broad goal "to ensure an adequate and reliable supply of safe, cost-effective drugs of acceptable quality to all citizens of South Africa and the rational use of drugs by prescribers, dispensers and consumers" (Department of Health 1996:3).

### Summary

There has been a dramatic increase in the use of pharmaceutical products in the Third World during the past 30 years. Many of these products have been incorporated into indigenous healing traditions. Unfortunately these products often have limited benefits or are useless for the types of health problems experienced by Third World populations. In addition, there is gross misuse of prescribed and over-the-counter products taking place with people buying medicines from street vendors and stores. In spite of World Health Organization recommendations about the need for "essential drugs programs" and "rational use, problems persist on many levels. The pharmaceutical industry still manufactures and promotes unnecessary products, while the essential ones stay unavailable; governments fail to regulate the market; and users continue to use products in ways that products were never intended for. All of this has serious implications for Third



World children whose parents believe they can ensure their children's health by administering medicines for prophylactic and curative reasons. The proliferation of pharmaceutical use has captured the attention of anthropologists who began to point that there is a need to understand the ways in which local populations use these products.

## CHAPTER 3 PHARMACEUTICAL ANTHROPOLOGY AND THE STUDY OF MEDICINE

### **Introduction: The Need for Local Perspectives**

One thing is certain: systematic research into people's ideas and practices with regard to Western pharmaceuticals has yet to be carried out and documented on any scale worth mentioning in the Third World. Almost nothing is known about drug use or users in local communities (Van der Geest 1987b:274).

By the mid 1980s, despite the general agreement on the gross misuse of pharmaceutical products, very few studies were actually available on how ordinary people in the Third World perceive and use drugs or why pharmaceutical products were so popular. Most of the early studies on pharmaceuticals were general criticisms that focused on international policies, national governments, and the pharmaceutical industry. The main problem with these publications was their failure to take local perspectives into account and overlooking of the cultural and symbolic meaning of drugs (Van der Geest 1987b:274).

Past studies that focused on consumers usually looked at patient compliance. This has apparently not changed much. Trostle (1996:1117) mentions, for example, that between 1986 and 1995 there were more than 8000 articles published on patient compliance. Most of these studies disregard the cultural and social contexts in which medicine use takes place. This is also true for South Africa. The small number of articles that do not deal with patient compliance, discuss self-medication (Buchanan 1979); attitudes of medical practitioners towards package inserts (Joubert and Skene 1984); the

proprietary medicine industry (Reekie and Scott 1988); and dispensing habits of pharmacists (Barron et al. 1989). Although ethnographic studies on southern Africa frequently mention the use of herbal medicine, they seldom mention the use of pharmaceutical products. Most of the anthropological references on the use of pharmaceutical products for self-medication in South Africa are only incidental (Booyens 1984; Brindley 1976; Du Toit 1990; Hellmann 1948; Koen 1986).

In the early 1980's an energetic effort was launched by a group of researchers associated with the Medical Anthropology Unit at the University of Amsterdam, the Royal Tropical Institute in Amsterdam and Health Action International to look at Third World consumers, especially at their self-medication practices. Following a pace setting review article "The Illegal Distribution of Western Medicines in Developing Countries: Pharmacists, Drug Pedlars, Injection Doctors and Others" (Van der Geest 1982) these researchers published a series of influential articles and books over the next decade that laid the foundation for Pharmaceutical Anthropology. This was followed by a number of articles, books and annotated bibliography (Etkin and Tan 1994; Hardon et al. 1991; Van der Geest and Whyte 1988). The 1996 Annual Review of Anthropology article by Van der Geest et al. "The Anthropology of Pharmaceuticals: A Biographical Approach" confirms the position of Pharmaceutical Anthropology as an exciting new area in Medical Anthropology. Unfortunately, in spite of this, there are still only a small number of anthropologists actively doing research in this field world wide.

### **Anthropology and the Study of Pharmaceuticals: An Exotic Bias?**

Why is there so little research, in general, on the cultural aspects of the use of pharmaceuticals in the Third World? And why did the volume of research only start to pick up in the 1990s?

Van der Geest (1987b) suggests a number of reasons for this slow start. Firstly, there are many methodological and logistic problems involved in research on medicines, especially because of the need for in-depth interviews and observation in Third World locations. In addition it is not always easy to find funding for detailed studies. Secondly, the disciplinary backgrounds (medical-pharmaceutical) of researchers interested in pharmaceutical products usually prevent them from focusing on cultural and social aspects of health in their research. Thirdly, medical anthropologists tend to focus on traditional medicine. It does not occur to many anthropologists that pharmaceutical products and "the way people perceived and used them might be an 'exciting' as well as a useful research topic" (Van der Geest 1987b:275).

Van der Geest also blames the "exotic bias" in anthropology for preventing anthropologists from seeing how pharmaceutical products were being incorporated into indigenous healing traditions. "Buying so-called modern drugs in local stores and market booths had already become established practice while anthropologists continued to write exclusively about ritual treatments and medical herbs" (Van der Geest et al. 1996:161). Geertz (1976) is an example of the exception because of his description of the use of patent medicine in Java.

The 1996 Annual Review article on Pharmaceutical Anthropology suggests that the recent interest in the study of pharmaceuticals is probably due to a new interest in Western culture and products, and thus bio-medicine has become a cultural phenomenon worth

studying (Van der Geest et al. 1996:155). This comes in addition to the renewed interests in understanding processes of globalization in terms of transnational cultural flows: "political ideals, entertainment, institutional forms, fashions, and commodities both transformed and were transformed by the contexts through which they moved" (Van der Geest et al. 1996:155). Biomedicine, and specifically pharmaceutical products, are viewed as a good example of this globalizing process and therefore anthropologists are becoming more interested in looking at them.

### **Research Themes in Pharmaceutical Anthropology**

Most anthropological research on medicines focuses on what Kleinman (1980) termed the "folk" and "popular" sectors. In those contexts researchers explore the meanings people attach to medicines, the ways in which medicines are interpreted in relation to their physical characteristics and form, as well as the metaphoric aspects of medicine (Van der Geest et al. 1996:155). The rest of the studies focus on "the eclectic use of medicines, and health care providers in pluralistic health care arenas, illness and age-specific medicine preferences and pharmaceutical behavior, and patterns of self-care" (Nichter and Vuckovic 1994:1521).

Van der Geest et al. (1996) distinguish five broad research themes that are connected with what they call the "life stages" of pharmaceutical products. These stages are: production, marketing, prescription, distribution and use of medicines.

## Production and Marketing

Very few anthropological studies have been done on production and marketing. The ones done are largely on advertisements, drug information inserts, drug compendia, production and sales figures, and government policies to curtail the influence of drug companies (Van der Geest et al. 1996:157). One of the problems with doing research on drugs, is the potential for the pharmaceutical industry to exploit the findings on the social and cultural aspects of medicine's use. The industry defensively argues that they are culturally sensitive and never impose Western standards on non-Western peoples like the critics of the industry do. The industry insists it is only supplying "what people welcome as useful and effective". It is ironic however, as Van der Geest et al. point out, that:

pharmaceutical companies delivering products that, from a biomedical perspective, are dubious, useless, or dangerous, can defend their practice thanks to anthropological studies that show that people cherish vitamins, blood tonics, antidiarrheal medicines, and hormonal preparations (Van der Geest et al. 1996:158).

Anthropologists studying advertising tendencies identified three broad trends in pharmaceutical advertising (Nichter and Vuckovic 1994:1518). These trends are: Firstly, advertisements for products combining ideas about the modern as well as the traditional. For example, advertising Ayurvedic drugs with English names in India. The English name is associated with modernity and quality while the association with Ayurvedic conveys a "sense of humoral compatibility and safety and the absence of side-effects." This style of advertising makes certain medicines appear "scientific". Companies also use the reverse: - they use traditional names on modern medicine - packaging common over-the-counter products such as vitamins or antacids as traditional. Secondly, the use of images of naturalness because of the appeal of natural medicine to the public. For example,

Lennon's in South Africa advertise their Dutch medicines as "Lennon's Natural Medicines". Thirdly, stressing the power and/or safety aspects of a medicine. The strength of a product is frequently used to attract consumers to a specific product (For example, using the name "Extra Strength Tylenol" or by emphasizing that the product contains both Aspirin and Ibuprofen). Safety is increasingly used as an advertising angle by citing what the product does not contain (e.g. caffeine free, sodium free, contains no narcotic, contains no hormones). This feeds on consumer awareness of a list of popular unsafe or unhealthy ingredients.

### **Prescription and Distribution**

Many anthropologists focus on the prescription of pharmaceutical products. Their main contribution is that they stretch our imagination about what a prescriber is. People involved in prescribing pharmaceutical products transcend our traditional categories of medical doctors, pharmacists, nurses and other health workers, because today they also include storekeepers, drug peddlers and indigenous healers (Van der Geest et al. 1996:159).

There are very few detailed descriptions on the distribution of pharmaceutical products. Studies up to now have been mainly contextual descriptions of drug selling and more analytical studies that contrast and compare private/public and formal/informal distribution, which have viewed distribution in the light of state policy, and discussed commodification and commercial aspects (Van der Geest et al. 1996:162). Most studies focus on pharmacies, health workers in hospitals and clinics and informal vendors that sell in markets, at taxi parks, truck stations, or on trains and on buses.

Some of the more dramatic contributions include descriptions of the extent to which Third World users can buy prescription drugs without a prescription from pharmacists or street vendors. Anthropologists point out that a big part of the problem is failing government health-care policies that lead to health professional and drug shortages, which in turn encourages people to self-medicate with prescription and over-the-counter medicines. This situation obviously is an advantage to pharmaceutical companies who benefit from the booming informal medicine market.

### **Medicine Use**

The three themes commonly addressed in the literature on medicine use are compliance and non-compliance, self-medication, and conceptual aspects associated with the use of pharmaceutical products.

#### **Compliance and non-compliance**

Compliance studies are almost always done from the bio-medical perspective. This makes it necessary to study non-compliance from the patient's point of view. The assumption is frequently made that compliance to traditional medicine is higher than compliance to biomedicine because traditional treatments are better understood by patients, but as Nichter and Vuckovic (1994:1513 ) point out there is very little research to confirm or deny this claim.

Taking medicine in a different way than recommended by a health professional is often described as illogical or irrational but labeling it negatively makes it impossible to look for "other rationales guiding medicine taking and medicine giving behavior" (Nichter and Vuckovic 1994:1514). There is therefore an urgent need to look at factors influencing compliance or non-compliance with medical advice for patients as well as prescribers. For



example, why do doctors prescribe pills and liquid medicines, against the WHO recommendations, for common childhood diarrhea instead of oral rehydration therapy, or prescribe a medicine in addition to oral rehydration therapy (Nichter and Vuckovic 1994:1514).

### **Self-medication<sup>20</sup>**

Although self-medication is one of the most widespread forms of illness management, it is the least studied in both the Third World and the West (Van der Geest 1987b:275). The scanty attention given by anthropologists to this subject is probably due to the fact that it is viewed as something obvious and not very spectacular (Van der Geest et al. 1996:164-165; Hardon 1987 on Philippines; Van der Geest 1987a on Cameroon). There is also very little understanding of why and how consumers use medicines for self-medication.

Most self-medication in South Africa is with over-the-counter medicine. Although this is not the case everywhere in the world, it is also true for the USA where more than 50% of all mothers surveyed in a US nationally representative study had given their 3-year-olds an OTC medication, primarily Tylenol or cough or cold medicines, during the previous 30 days (Chetley 1988:12).

Self-medication is popular because it is convenient, economical and easily available. It is especially appealing to poor and disempowered people because it gives them a sense of control over their own health. Self-medication is also popular because medicines are seen as the essence of bio-medicine, making a visit and especially payment for a visit to the doctor or clinic unnecessary. Experts are only consulted when

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<sup>20</sup>Self-medication is defined as: "the use of any systemic or topical substance reported by the user as being used for health related purposes that is not prescribed by a registered doctor specifically for the person or the condition. They may be used for the treatment of illness (referred to as medicines), or the promotion of health (referred to as tonics)" (Lam et al. 1994:1641).

a problem persists: it is only at that point that the person surrenders control. "By definition, self-medication is practiced outside the control of medical professionals, usually at home" (Van der Geest et al. 1996:165).

Although self care has the potential to make people self reliant and could contribute to the success of primary health care, it is not clear how empowering it is, because we know very little about the basis on which individuals make decisions to use a specific product. How much for example are they influenced by marketing claims of products? As Nichter and Vuckovic say: "although self-medication may free individuals from 'the hegemony of professionals', it may do so only to shift control more directly to the pharmaceutical industry" (1994:1519).

### The Meaning of Medicine

One of the central questions pharmaceutical anthropologists have been trying to answer is why pharmaceutical products are so popular in their use for the treatment of illness? Part of the answer is in the multi dimensionality of medicines. They are at the same time concrete and symbolic, social and magic. They have the potential to transform the condition of humans - for good or for bad. This power that medicines have, has always appealed to people. Medicines can cure people, but medicines can also kill people. By using medicines, people feel that they can do something active and concrete about their well-being. Because of that medicines can be used to ward off illness thus ensuring good health (Michel 1985; Bledsoe and Gouband 1985).

Traditional Yoruba believe that sickness is caused by forces outside the body. It was therefore considered to be extremely important to take medicines regularly, in order to keep healthy. Medicines were either burnt and the ashes rubbed into the body, or drunk or bathed in. Children needed particular attention, since the infant mortality rate was so high (Meldrum 1984:176)

This example illustrates that what is understood in the Western world under preventative medicine is not necessarily everyone's idea. This is also true for curative medicines. Nichter and Vuckovic (1994:1511-1512) give examples of where curative medicine is used as "talismans to ward off illness or to promote a general sense of well-being". For example, in Guatemala, bottles of intravenous glucose are sometimes used as wedding gifts to promote vitality and protect against illness, and in the Philippines mothers use the anti-TB syrup isoniazid (INH), believed to be 'vitamins for the lungs', for children with "weak lungs" (a term used to denote a wide range of illnesses).

For Van der Geest et al. (1996:154) the power of medicines is in their concreteness - you can swallow it or smear it on your body or you can put it in your orifices. It is not just about the chemical effect since there are "medicine" like talismans that can be worn around the neck, the arm or waist whose chemical content cannot have a direct influence on your well-being (Van der Geest, Whyte and Hardon 1996:153). And we do know that medicines without any chemical content (placebos) can have an effect on people.

For Van der Geest (1987b:274) "The ultimate meaning of medication is not determined by the doctor writing a prescription, but rather by the person taking - or refusing to take - the medicine" while Helman (1996) suggests that the way to look at medicines is to look at the "total drug effect". The total drug effect includes the characteristics of the medicine (color, taste, smell, name, shape), the characteristics of the user (personality, social and cultural background), the provider of the medicine and the situation (context) in which the medicine was acquired to explain medicines' power and attractiveness.

In the following sections different aspects of this total effect will be briefly highlighted.

## Consumer Demand

Van der Geest (1987b:274), following early anthropologists such as Malinowski, says *need* is a cultural concept and people learn what to need. To understand consumer demands we need to understand the cultural context in which they use medicines. For example we need to know what the "established patterns of medicine consumption (such as the felt need for liquid medicines, pills and/or injection) are, as well as popular health concerns (such as digestion and loss of vitality) (Nichter and Vuckovic 1994:1517).

## Social Interaction with Health Specialist

Pharmaceutical products enable individuals to "avoid complicated and expensive healing rituals" (Reeler 1996:126). In this context treatment takes place outside the professional domain of health professionals or indigenous healers. Avoiding professional assistance is becoming a trend with large numbers of people who self medicate. Nichter and Vuckovic observed in India that pharmacists' assistants were frequently the source of information about sexually transmitted diseases and abortion medicines. The reason for not asking the pharmacist is that users "feel more comfortable asking questions of attendants whose status was closer to or lower than their own and whose demeanor was less threatening than that of the pharmacist" (1994:1515) .

## Contagion

Ideas about contagion in the West usually involve thinking that taking medicine will make someone less contagious. This is not necessarily the case everywhere. Nichter and Vuckovic (1994:1515) make the point that "In cultures where contagion is strongly associated with contagious magic, the person may be perceived as more

contagious because a need for medicines calls attention to their condition and its seriousness". In South Africa, for example, taking strong African medicines<sup>21</sup> is viewed as "contagious" and potentially harmful to the people around the person who has taken the medicine (Chapter 6 and 8). The interesting question in South Africa is: Do we know which pharmaceutical products are viewed as African medicines? Are there any other medicines that are seen as so strong that they could affect (be contagious to) the people (especially children) that the person taking the medicine is in contact with. Could this have an effect on prescription medicine taking?

### **Medication as Markers of Social Identity**

In households with scarce resources not everyone has equal access to medicines. In some cases the breadwinners are favored and in other cases male children are favored over female children.

### **Medication as an Idiom for Distress or Affection**

Medicines can be symbols of care and affection. Giving your child medicine to ensure continuing health (protecting your child with medicine) sends a special message about the kind of mother you are. Not giving your child medicine sets you socially apart from mothers who do use it. (Nichter and Vuckovic (1994:1516) illustrate the point by writing that "The symbolism is less obvious, but no less powerful, when promotive medicines are purchased to convey affection and alliance. The South Indian husband living in an extended family who purchases a tonic for his overworked wife is able to express caring through the act".

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<sup>21</sup>Sotho speakers, like other Africans in Soweto, make a distinction between *Ditlare tsa Sesotho* or *Setho* (medicine of African culture) and *Ditlare tsa Sekgoa* (medicine of White culture)

### **Efficacy and Side-effects**

Efficacy and side-effects are often culturally constructed (Etkin 1992). Side-effects are for example often considered as a sign of strong medicine. "The cultural efficacy of pharmaceuticals lies primarily in their capacity to carry meanings" (Van der Geest et al. 1996:169). In other words the symbolic meanings carried by pharmaceutical products play an important role in the strength people assign to specific products.

### **Product Inserts**

Product inserts are supposed to enable individuals to avoid the risk of serious side-effects. But on the other hand the insert could also be used to reinterpret the drug for other uses. "The adverse side effect of a drug may constitute a desired primary effect for some individuals" (Nichter and Vuckovic 1994:1513). For example, in places like the Philippines, where abortion is illegal, package inserts that provide indications that specific medicines should not be used by pregnant women as they could result in a termination of pregnancy, are then indeed used as abortifacients. The apparent use of cloroquine in South Africa as abortifacient are currently under investigation by the University of Natal.

### **Place of Origin**

The place of origin of a medicine is often seen as important in the construction of efficacy. "The belief that medicines that come from afar are stronger than native ones is present in many cultures" (Van der Geest, Whyte and Hardon 1996:168). Western pharmaceutical products are for this reason often attributed with power and status. "The pharmaceutical drug is an extension not only of the doctor and his medical

expertise but also the whole scientific culture of the West with all the associated images of power and highly specialized technology" (Reeler 1996:127).

### **Ritual Objects**

Pharmaceutical products are also ritual objects, for example, "facilitating transitions from one phase to another, from health to sickness and back" (Van der Geest et al. 1996:168). Ritual effect is particularly strong in the way infants are treated with Dutch medicines to prevent them from falling ill (Chapter 8).

### **Explaining and Diagnosing Illness**

There are indications that medicines are used to diagnose illnesses. For example the Ndembu healers in Zambia diagnose illnesses as African or European by whether or not people respond to western medicine (Nichter and Vuckovic 1994:1514).

Medical anthropologists have paid considerable attention to explanatory models of illness emphasizing the why and when of illness and not much on how "patients derive meanings about illness and body states from the medicines they are prescribed or choose to take" (Nichter and Vuckovic 1994:1514). People often evaluate their illness in terms of what they have to take to get rid of the problem. "Medications inform the interpretation of illness to the extent that explanatory models for illness are often framed in terms of the type, strength and quantity of medications consumed"(Nichter and Vuckovic 1994:1514). Haak (1988) reports that in Brazil, if a prescription contains only a few drugs it is an indication that the illness is not very serious or that the number of medicines predicts the speed of recovery.

## Indigenisation of Medicines

Pharmaceuticals are increasingly used, not as alternatives to indigenous medicine but as indigenous medicine (Etkin et al. 1990:919). The process whereby a pharmaceutical product is transformed, adopted and incorporated into a local healing system so that it becomes accepted as an authentic indigenous product is known as indigenisation. The reasons for this is that the:

Integration of western pharmaceuticals into local culture is achieved in various ways: traditional concepts of efficacy are used to describe their effects; western pharmaceuticals are sold alongside other daily requirements in small neighbourhood shops; they are used in a cultural specific way (for example pounded and sprinkled on wounds); they receive local names and, conversely, give their names to traditional medicines (Haak and Hardon 1988:621).

## Summary

Before the 1980s there were only a few anthropological studies on the perceptions and use of pharmaceutical products by people in the Third World. Most of these studies focused on policy issues and the pharmaceutical industry. Anthropologists' initial lack of interest can be blamed on their traditional focus on "exotic practices" and a dismissal of "Western practices" as an interesting topic to study. But once they focused on the use of Western pharmaceutical products, they discovered that people in the Third World indigenise pharmaceuticals through a process of reinterpretation, and incorporate them into indigenous healing traditions. This process has also been taking place in South Africa where one of the best examples is the indigenisation of Dutch medicines over the past 200 years.



## CHAPTER 4 DUTCH MEDICINES: FROM GERMANY FOR SOUTH AFRICA

### Introduction

No pharmacy or store in South Africa is complete without at least one shelf lined with 5 by 4 inch yellow and red boxes containing different kinds of "Dutch Medicines". Each of these boxes has space for twelve little yellow and red boxes containing a 20 ml bottle. They are from Lennon's, the most popular brand name (and almost 150 years old) who sell almost 50 different kinds of Dutch Medicines marketed as "Lennon's Natural Medicines".

A free Dutch Medicine Handbook, available in different South African languages, gives guidance to the use of the different medicines. Except for one, all the medicines are over-the-counter products and sell for just over \$1 each. They are all well-known and marketed by their Afrikaans names. These names, even for an Afrikaans-speaker, have an exotic ring and remind one of something out of another era: *Balsem-Kopiva*, *Groen Amara*, *Haarlemensis*, *Paragoriese Elikser*, *Duiwelsdrek*, *Doepa*, *Wonderkroon*.

Depending on one's cultural background, when buying them one would ask for either *Hollandse Medisyne* (Dutch medicine), Lennon's (a reference to the main manufacturer), *Didruppels* (a word used in Soweto literally meaning the drops), *Stuips* (using one of the Dutch Medicines, *Stuipdruppels*, as a generic name), *Iteipi*, *Seteipi* or *Setipi* (using the same Dutch Medicine, *Stuipdruppels*, as a generic name, but indigenising the name to have an African sound) or *Dibotlolo tsa bana* (the bottles for babies).

As people have done in the past, one could buy a bottle and use it as indicated, or have a list of bottles for mixing in a "recipe" to treat a specific illness, or for use as powerful protection against illness and misfortune.

Dutch medicines are an example of a blending of European inheritance, local additions and new additions. Dutch Medicines have a history in South Africa that stretches back for almost 200 years and probably represent one of the earliest South African examples of the indigenisation of medicines. Most of the medicines originated in Europe and were first associated with the Dutch Settlers in the Cape, specifically with the *Trekboers* during the 1800s, and Afrikaners during the early part of the 1900s. As their popularity grew during the last half of the 20<sup>th</sup> century users include virtually every cultural group in South Africa.

In this chapter I will explore the history of Dutch medicines during the 19<sup>th</sup> and 20<sup>th</sup> centuries in some detail.

### **Spices and Drugs in Europe**

Most of the ingredients currently used in Dutch Medicines can be traced back to the Medieval and Renaissance herbals. The herbals were mostly based on Dioscorides' (AD 20-79) *Materia Medica*, which superseded the works of Theophrastus (fl 370 BC), Krateuas (fl 120 BC) and Pliny (27 BC - AD 36) (Guerra 1966:29). From Dioscorides' *Materia Medica*, Galen extensively borrowed and incorporated substances into his medical system (Stannard 1966:4). Many of these substances, also known as vegetable simples, or galenicals are in fact similar to many of the main components in Dutch Medicines (Appendix C).

It is not always acknowledged that these early writers depended heavily on drugs from the Orient or "carried out their studies in Levantine<sup>1</sup> areas which were on the traditional caravan routes for drugs and spices" (Guerra 1966:29). The European medicines originated from Egyptian, Greek, Roman, Arabian and Indian sources and, later from the Americas. They included aloes, opium, pepper, sandalwood, Persian rhubarb, and camphor<sup>2</sup>. Haggard (1929:332) and others argue that the spice trade was really a medicines trade and that the search for new trade routes was directly linked to the search for cheap fresh drugs. Guerra sums it up by saying that

the spices, now merely regarded as food condiments, were also used in those days as important drugs, and their heat, dryness and other physical properties could be readily ascertained by the senses, both of doctor and patients. Therefore, pepper, ginger, cinnamon, cloves, nutmeg and other botanical materials, from the standpoint of traditional humoral pathology, were well fitted to influence with their qualities the humours and morbid processes in the body, ranking second only to cathartics as the most popular remedies. Drugs and spices were sold on the same premises, and the terms spices, drugs and aromatics were generic and interchangeable all through these years. In some countries, such as Great Britain, the apothecary was a member of the Spicers and Pepperers, later the Grocers' Guild, until well into the 17<sup>th</sup> century (Guerra 1966:29-30).

Initially (around 500 BC) Greek medicine did not include an extensive use of drugs. It was only later, under the influence of the teachings emanating from the University of

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<sup>1</sup>"The spice trade had been centered for centuries on the Levant. The term (spice) included all seasoning, medicinal drugs, perfumes and dyestuffs from Asia and Africa, first handled and marketed by the Egyptians, then by the Romans, only to be moved north to Trebizond by the Genoese, but subsequently returning to the ports of Alexandria, Beirut and Aleppo when the Venetians acquired a major interest in the spice trade" (Guerra 1966:30).

<sup>2</sup>Various early travellers, for example, Marco Polo (1254-1324), gave detailed descriptions of stones, metals and medical plants in their natural environments including Aloe, Ambergis, Balm, Bastard saffron, Camphor, Cinnamon, Cloves, Cubebs, Cummin, Galingale, Ginger, Hashish, Incense, Musk, Nard, Pepper, Rhubarb, Sandalwood, Sesame oil, Sugar, Tamarind and Turbit (Guerra 1966:30-31).

Alexandria and intimate contact with the Romans, that Greek medicine began to incorporate the use of drugs (Haggard 1929:337-338). Because of this increased use and demand for drugs, Dioscorides, who traveled widely and gathered information on all kinds of medicines, compiled the first *Materia Medica*.

It was on this *Materia Medica* that the Herbals were based. The Herbals were books that described the "cultivation, collection, and properties of herbs" (Haggard 1929:338). These books were the common books of medical knowledge during the medieval period and people treated themselves according to the directions of the Herbals "just as people of a few years ago dosed themselves with the remedies described in almanacs, and as they do today (1929) with the drugs described in newspaper advertisements" (Haggard 1929:338).

### **Humoral Medicine**

Dutch Medicines can also be linked to humoral medicine and the treatments associated with it. These ideas were still widespread during the 17<sup>th</sup> century when the Dutch reached the Cape of Good Hope and settlers from many parts of Europe established themselves in southern Africa.

It is widely held that a healthy body is dependent on a "harmonious balance between two or more elements or forces" within the body. The balance could be disturbed by forces inside the body (for example inherited weakness) or outside the body (supernatural agents) (Helman 1996:17-18). The Greek *humoral* theory, with its ancient Chinese and Indian origins, is probably the most widespread of the "balance" theories.

The original theories were elaborated on by Hippocrates who believed that the body contained four liquids or humors: blood, phlegm, yellow bile and black bile. If the four

humors are in balance good health is the result, but if they are out of balance the result is ill-health.

Treatment for imbalance/disease consisted of restoring the optimal proportion of the humors by removing excess (by bleeding, purging, vomiting, starvation), or by replacing the deficiency (by special diets, medicines, and so on) (Helman 1996:18).

Hippocratic medicine was elaborated on by Galen (AD 130-200), a Greek physician. In Galen's system the body, like the universe, was made up of four elements: fire, air, water, and earth. Fire is hot, air is dry, water is wet and earth is cold. Each of these elements must be preserved in its proper proportions in the body to maintain good health. When the balance is disturbed ill-health is the result and the balance must be restored by using drugs with the proper qualities: cooling, heating, moistening, or drying (Haggard 1929:340).

Galen used elaborate mixtures of herbs in order to restore the proper balance of qualities in the body. Thousands of drugs were part of the Galenic system. A single prescription commonly included more than a hundred different drugs. Galen's disciples in the following centuries carried on with this practice. People who could not afford a physician to prepare a medicine bought the necessary drugs from dealers and prepared it themselves. "Even after the Galenic system was dropped by physicians it persisted as the use of herbs for home remedies... It also persisted in proprietary medicines..." (Haggard 1929:340).

After his death, Galen's ideas spread through the Roman world and into the Islamic world. Parts of his work were translated into Arabic in the 9<sup>th</sup> century and entered Spain and Portugal during the Moorish occupation. "Today, humoral medicine remains the basis

of lay beliefs in much of Latin America, is prominent in the Islamic world, and is a component of the Ayurvedic medical tradition in India" (Helman 1996:18).

### Medicines at the Cape

The Galenic concept of noxious humors requiring to be dispelled died hard, and consequently blood-letting, purging and vomiting remained standard procedures for all manner of illnesses. Those of the *trekkers' middels* that were not analgesic in their action were intended for cleansing the bowel (Burrows 1958:194).

When the Europeans arrived at the Cape of Good Hope in 1652 they brought with them the current European beliefs about health and illness, as well as medicines to treat ailments. But because of contact with sailors and slaves from the East<sup>3</sup>, as well as contact with indigenous peoples (especially the Khoi), a "unique pattern of folk medicine" soon developed (Burrows 1958:67). As free burghers moved away from the Cape inland, they had to become more self-reliant. It was especially the *trekboeren*<sup>4</sup> who moved beyond the mountains that began to use indigenous herbal remedies used by the Khoi and experimented with herbs and plants that flourish around them (Watt 1927:528-534). From this they learned which ones could be used as purgatives, emetics, cathartics and diuretics.

In addition to what Burrows (1958:67) calls a "*boeren-pharmacopoeia*", country people also used patent medicines. In the early 1800s most homes had a *huis-apotheek*

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<sup>3</sup>"European medicine exerted the greatest influence, although it must be remembered that as a port of call between Holland and the East it was inevitable that contact would be made with Eastern drugs" (Price 1974:1129).

<sup>4</sup>*Boer* means farmer, equivalent of the pioneers who moved West. In time *boer* became *Boer* to refer to the frontier Afrikaner for example, Anglo-Boer War.

(home medicine chest) filled with Halle medicines ordered from the Cape apothecaries or purchased from *smouse* (traveling salesmen) and *meesters* (literally meaning “masters” or “teachers” who were drug peddler). The demand for patent medicines was very strong, despite the presence of qualified medical practitioners in the countryside. A long list of complaints were lodged by medical doctors over the use and sale of Dutch medicines to rural people.

Burrows explains that

it was not easy to make the farmers a more acceptable present than a glass of *pulvis antispasmodicus*, or *essentia dulcis*”, wrote the traveler Lichtenstein, who traveled through the Colony in 1803-1806. At each halt inland a vast number of sick and infirm people assembled to seek his advice, so much so that he was unable to provide all with medicines. Instead he made use of the local medicinal plants of the veld and for the rest he prescribed the Halle medicines, not that he believed in them himself, he added, but his patients did so and appeared to benefit by them! (Burrows 1958:68).

The were numerous complaints. A young doctor at Swellendam, for example, complained to Lichtenstein that

farmers purchased mostly emetics and cathartics and that nobody subsists in these parts by the ordinary practice of medicines, because there was not a colonist who had not rather be his own physician, and who sought skilled help only in extremity (Laider 1938:14-15).

And Dr John Atherstone who settled in Uitenhage in 1820 bemoaned the fact that:

his success in the town itself was complete, but in the country absolute nil, the non-progressive Boer, with his outdoor life and frugal habits, believing only in the *Huis-Apotheek* which sufficed for all his real and imaginary ailments. These have ever since been sold by *smouses* and chemists down to the present day (Burrows 1958:155).

In 1853 Dr Way from Burghersdorp complained about

the great evil which exists in the country districts, among an ignorant population, is the attachment of the Dutch Boers to the Hallerian medicines, and the universal sale of them by the storekeeper... Among the enlightened Boers of the Frontier there is evident a growing confidence in professional skill, but the mass are profoundly ignorant and prejudiced... The storekeepers naturally foment this prejudice by recommending the medicines ... and so a town which could support a doctor has only a quack (Burrows 1958:186-187).

We can safely deduce from all these complaints that country people heavily relied on patent medicines. *Huis-apotheke* filled with Halle medicine (later known as Dutch medicines) were firmly established in *boer* households by the mid 1800's.

### *Huis-apotheek*

The *huis-apotheek* is not uniquely South African as many people like to believe. *Haus apotheke* and *Reise apothekewere* well known in Europe since the 1600s (Schelenz 1904:514).

The *huis-apotheek* or Family Medicine Chest appeared at the beginning of the 19<sup>th</sup> century in South Africa. The earliest list of the contents of one of these medicine chests used in the Cape is from an inventory of the *huis-apotheek* of the Cape Governor, J. Van Plettenberg (1774-1785) (Hoge 1947:3-6). Except for *Droppels van Hoffman*<sup>5</sup> *tegens schrik, alteration en vapeurs*<sup>6</sup> (*Hoffmansdruppels* against fright and hysteria), none of his medicines can really be classified as Dutch medicines. An interesting item that reminds us

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<sup>5</sup>*Hoffmandruppels*

<sup>6</sup>*Vapeurs* means hysteria caused by gasses from the stomach rising to the brain and sedating the person. The French word was well known all over Europe in the 18<sup>th</sup> century (Schulz 1947:49).



of the way *Doepa*<sup>7</sup> was later used is the *Rookkaarsjes tegen kwade lugt* (Smoke candles against bad air). By the middle of the 18<sup>th</sup> century every Boer family had a *huis-apotheek* with Halle medicines. Dr Henry Taylor who lived in Ficksburg in the Orange Free State, describes in his memoirs (1877-1906) how

every Boer house, however poor, possessed a *huis-apotheek*, or domestic medicine chest, a tin box containing some 20 ounce-bottles of various medicines. When there was illness in the family small doses from half a dozen of these drugs were mixed together haphazardly and given to the patient. Fortunately they were most of them innocuous and, beyond being very nasty, did neither good nor harm to the invalid" (Hadley 1972:130).

Each household had its own medicine-chest or *trommel*, usually the readymade *huis-apotheek* of the Cape Town chemists with the Halle medicines which proved such strong competition for the boundary doctors. A typical *trommel*, measuring about nine by six inches, had cubicles for the various bottles and spaces for the plasters, salves and medicaments it contained, and in each there was a booklet of directions giving an elementary description of the various illnesses as well. By this means an interested person could become experienced in their uses and efficacy. If one *midde*<sup>8</sup> did not act favourably, then another was tried or perhaps a combination of two or more and although each preparation appears to have enjoyed an almost unlimited field of usefulness, old hands became adept at knowing the right remedy for the right disease (Burrows 1958:191).

Every little metal chest (*bliktrommeltjie*) has 25 small partitions where a little bottle can fit in. Most of the major companies advertised a little chest, for example, a green metal one from Petersen and a wooden or metal one from Lennon's (Van Wyk 1996:61-62).

These *huisapotheken* were popular and commonly used throughout the 19<sup>th</sup> century until around WWII in South Africa. Spoelstra mentions that around 1875 every family had a metal chest with real Dutch medicine and with every chest people received a little book

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<sup>7</sup>Chapter 8

<sup>8</sup>Medicine

telling them about different diseases and a summary of which kind of Dutch medicines to use (Coetzee 1944:24). According to Coetzee (1944:26) *huisapotheken* were still available from chemists or stores at the time of his article.

### Dutch Medicine from Halle, Germany

Professor August Francke founded the Frankish orphanage in 1698 in Halle, Magdeburg, Germany (Ryan 1986:3; Schelenz 1904:517). A newspaper article in 1834 reported that the orphanage succeeded in "the caring for and training of thousands of orphans with the use of the proceeds from their medicines sales" (Van Rooyen 1944:88). These medicines from the German orphanage became known as *Hallesche Medicamenten* and formed the foundation of today's Dutch Medicines in South Africa. The Halle medicines were well known to the German physicians and apothecaries that worked for the Dutch East India Company and were sold for most of the 19<sup>th</sup> century (Ryan 1986:3).

The earliest indication of the use of "Hallesche" medicine in South Africa (around 1803-1806) is from a description by Petrus B. Borchers (Van Rooyen 1944:37).

In his history of medicine in South Africa, Burrows (1958) refers to the first traveling druggist named Drege. The latter's diary contains descriptions of him writing out prescriptions, trading and bartering his medicines in the country-side. Burrows (1958:156) sees Drege as an example of a *wonderdoener*(quack). His diary mentions that on one of his travels in 1831 he took: "353 dozen grey and white emetic powders (most likely

*graauwe* and *witte vomitieven*<sup>9</sup>), rhubarb, aniseed pills, 120 pieces of Nurenbeg plaster in boxes, herbs, totaling 237 parcels". (Laider 1938:14).

There is archival evidence that the *Trekboers* were familiar with Halle medicine in the beginning of the 19<sup>th</sup> century. The diary of Trichardt (1834) began with several paragraphs from the Von Madai *Kort Bericht*, an apparent attempt to copy the pamphlet (Preller 1938:1). Trichardt probably did not finish because he managed to get hold of a copy.

The first Hallesche Medicamenten Depot was created in February 1835 in the former apothecary of Dr F.L. Liesching<sup>10</sup> and Co at 87 Loopstraat, Cape Town. Dr Carel F. Juritz, Commissioner of the *Hallesche Medicamenten Expeditie* was the proprietor and the name of the establishment the Engel Apotheek (Angel Dispensary), signified by a Mercury in a window-frame (Laider 1938:5).

### What Is in a Name?

Initially, in the early 18<sup>th</sup> century the name Halle medicine was used in South Africa to refer to medicine exclusively from Halle, Germany, but it slowly also began to refer to medicine made by different Cape Town apothecaries using Halle recipes or Halle medicine names. Originally known as *Hallesche Weeshuys-Medicamenten* (1776) variations of the name began to surface, for example, Halle medicine. By 1840 Halle medicine began to be

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<sup>9</sup>*Graauwe* (grey) and *Witte vomitieven* (white purgatives) existed well into the 20<sup>th</sup> century.

<sup>10</sup>Dr F.L. Liesching, a Surgeon-Major to a German mercenary regiment, arrived in Cape Town in 1787. He petitioned the government in 1800 to open an Apothecary's shop in Cape Town. By 1806 there were 9 apothecaries in Cape Town.

used under a new name *Huismiddelen* (Van Zonnen 1840; Kort Berigt 1852), while later pamphlets use *Hollandse medisyne* (*Huismiddel*) (Dutch medicine/Home remedy) simultaneously until the 1980s.

How did Halle medicine became Dutch medicine? There are several possible explanations. It could be because the English colonists (in the 19<sup>th</sup> century) got to know these medicines through the Dutch colonists and the Dutch translated it back into their own language as *Hollandse medisyne*. *Hollandsche Medicijnen* or *Hollandse Medisyne*, could also be a corruption of the name *Halse* or *Hallesche*. Price (1974:1128-1129) says that the Halle medicine was known as Deutsche medicine which became Dutch medicine and was back translated as *Hollandse medisyne*.

Besides the linguistic arguments it could also be postulated that there was soon a demand for more than the customary 20 Halle medicines. This is because of local additions such as Buchu and *Entressdruppels* for example. When the contents of the different pamphlets are compared it becomes clear that there are numerous additions to the pamphlets. The 1852 pamphlet of *Voornaamste Huismiddelen* explains for example, that they increased the 20 basic Halle medicines to 34 "essential and powerful medicines". This was done in consultation with Drs Von Madai and Duffer of Halle, as well as with Dutch physicians (Kort Berigt 1852:3). Their 34 medicines are much closer to today's Dutch medicines than to the 20 original Von Madai medicines.

Medicine names were often indigenisation from Latin, Dutch and English to Afrikaans:

For example (Coetzee 1960:109):

besuardpoeier> beswartpoeier> beesswartpoeier  
 polychrestpille> polgraspille  
 solarispoeier> selarispoeier> salarispoeier  
 balsemsulfurus> balsemsevieres  
 haarlemmerolie> Hermansdrup  
 helmanskruide> Hermanskruie  
 endressdruppels> intrensdruuppels (entrance-druppels)  
 kraamdruppels> krampdruppels

### Pamphlets

Publishing pamphlets on the use of "Dutch Medicines" began a tradition that spans more than 250 years. These pamphlets and medicine advertisements tell us an interesting story of cultural change and the Africanization of European medicines. An assortment of pamphlets are available in the South African Library<sup>11</sup> and the Johannesburg Public Library. All of them accompanied Dutch Medicines sold by different companies in South Africa during the past two centuries. Many local companies used Von Madai's Kort Bericht as the basis of their pamphlets, adding new introductions, changing names, and adding or subtracting medicines.

The first edition of the Von Madai pamphlet was in 1741. The 114 page long fourth edition (1836) is the only available pamphlet in South Africa today. This pamphlet mentions that similar pamphlets are available in Latin and *Hoog-Duits* (High German), an indication that the orphanage's business was not limited to Africa.

From 1840 onwards the Dutch names were listed opposite the Latin names, and by the end of the century all the names were only in Dutch. The early part of the 1900s

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<sup>11</sup>The South African Library in Cape Town keeps copies of all material printed in South Africa, and in addition, archives Africana material.

introduced yet another language change. All the names appear in Afrikaans.<sup>12</sup> These names have stuck and are so closely associated with Dutch medicines that it does not matter that they are meaningless (linguistically) for the majority of users in South Africa today.

Many medicines that were locally used and not originally part of Dutch medicines, for example, *Doepa* and *Entressdruppels*, were added over time.

There is evidence from the pamphlets that the manufactures of Dutch medicine at least targeted English speaking South Africans as users. For example, the Lennon's Company's pamphlets of ca1891 and ca1900 are in both English and Afrikaans. The 1951 Heynes Mathew Dutch Medicines pamphlet is in both Afrikaans and English. It is interesting to note that while the Afrikaans introduction is addressed "*aan ons landgenote*" (to our countrymen), the English introduction is addressed "to our English speaking friends" and encourages them to use Dutch medicines because: "The reason for their hold on Afrikaans people of South Africa is because they have been continuously tried and found to be effective"

The number of medicines considered Dutch medicines changed from time to time. Von Madai's book contains the names of 20 medicines, the pamphlets of 1840, 1852 and 1856 lists 34 essential *huismiddels* (home remedies), while Juritz's pamphlet lists 89 *huismiddels* (many his own inventions). The number of Dutch medicines kept changing: In the Lennon's 1884 catalogue there are 113 Dutch medicines for sale, in both the ca1891 and ca1900 Lennon's pamphlets there are 35 names, the Heynes Mathew pamphlet of 1951 lists 105 Dutch medicines, while the South African Government's official list of 1957

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<sup>12</sup>Due to the change in status of the Afrikaans language. It became an official language in 1925.

contains 58 Dutch medicines. The Lennon's pamphlet of ca1900 has 75 names, the one of ca1970 41 names and the ca1990 pamphlet 26 names. In many ways it is a full circle and returning to the 20 something essential Dutch medicines.

### **Mixing Medicines**

Although pamphlets, listing and directing the use of Dutch medicines, were always part of the rural South African tradition, people also follow their own "recipes". Mixing medicines was a common practice. The Boers, for example, used two kinds of *deurmekaargood* (mixed medicines), one a mix for treating internal illnesses (a dozen bottles were mixed) and another for treating external problems (everything with an oil base, for example, castor oil, turpentine, sweet oil, was mixed) (Coetzee 1944:25-26). This tradition of pouring different Dutch medicines together continue to this day, as we will see in Chapter 8.

### **Summary**

Dutch medicines in South Africa represent an example of the process of indigenisation of pharmaceutical products. Originally from 17<sup>th</sup> century Europe, Dutch medicines have been reinterpreted and incorporated into different local healing traditions in South Africa over a period of 200 years. The pamphlets accompanying these medicines reflect the changes and continuities in their names and uses over time. There are many examples of how these medicines have been mixed and utilized by rural peoples. Originally part of Boer folk medicine in rural areas, Africans slowly began to use them too. As we will see in Chapter 8 they are now extensively used for warding off illness in African infants.

## CHAPTER 5 INTRODUCTION TO SOWETO AND SAMPLE

### Introduction

Soweto<sup>1</sup>, a sprawling city of more than two million people 15 miles from central Johannesburg, is probably one of South Africa's most recognized cities internationally. It was originally established as a "native location" and was to serve as a dormitory for Johannesburg's black workers. Soweto became a household name after the 1976 "Soweto student uprising" and since then has been frequently used to illustrate news stories about South Africa. For many people around the world, Soweto is a symbol of struggle against apartheid and one of the first places to go to when visiting South Africa. Sowetans have used their popularity with foreign tourists to create a small industry selling their city through township tours and visits to local taverns.

People from Soweto will often point out that they have created a "Soweteness" over the past 60 plus years. Although a culturally diverse city, Sowetans believe they are distinct in the way they dress and the way they speak--mixing together different styles and languages. Soweto is a cosmopolitan city where diverse groups of South Africans were thrown together in the early part of the century. They have blended together over time, in spite of government policies to separate neighborhoods by ethnic groups. Regardless of their urban sophistication (the Sowetan, a local newspaper has a daily circulation of one

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<sup>1</sup>Soweto is an acronym for South Western Townships, a name that was widely in use before officially decided on in 1963 (Mandy 1984:173).



million copies) Sowetans keep in touch with their rural roots in many different ways. Families often maintain two homes, one in Soweto and one in a rural area. Various family members move back and forth between these homes for work, education, health care, religious ceremonies, or marriage rituals.

### Historical Background

After the discovery of gold on the Witwatersrand in 1886 Johannesburg rapidly grew into a very large city as people were flocking to the area looking for work and wealth. By 1896, the population of this mining town was already over 80,000. At that time half of the population were African unskilled and illiterate male workers from the rural areas (Mandy 1984:174). Because of the economic boom created by the gold mines and related industries, and the subsequent population explosion, the Johannesburg area had housing shortages from the onset. Rural whites, Africans and Coloured<sup>2</sup> workers were crammed together in slums and freehold townships on the western side of town. One of the priorities of the new Union government in 1910 was to reduce overcrowding in cities and prevent slums in the "white" parts of town (Pumell 1993). Some of the slum areas in Johannesburg included "the Native Locations"--later called the Malay Location and then Pageview, the name the area still carries today; the "Coolie Location" originally near Burghersdorp and later near the Braamfontein Railway Station; the "Kaffir Location" south of the railway line near the present day Vrededorp subway (Carr 1990). The first opportunity to get rid of a slum area came in 1904 with the outbreak of Bubonic Plague in the Coolie Location. The Johannesburg City Council literally removed everybody overnight to the newly established

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<sup>2</sup>Persons of mixed descent.

Klipspruit Location (part of Greater Soweto today) for Africans and burned down all the shacks.

The regulation of African urbanization after WWI through the improvement of living conditions for urban workers, exclusion of unemployed workers from areas, the creation of hostels and the establishment of some housing for African families in town became a government priority. For example, Western Native Township was established in 1918 to address the housing shortage for Africans (Mandy 1984:174).

After 1930, with the continual growth of slum areas, very tight residential restrictions were imposed on urban Africans in an attempt to control urban poverty and regulate the African workforce by controlling urbanization of Africans. (Parnell 1993). This began a process, with the aid of many laws and regulations<sup>3</sup> for which Africans were never consulted, that allowed local governments to move people around, and restructure urban areas. Lewis, a former administrator of Soweto, says in a 1969 speech that

ninety acts of Parliament [were] passed between 1945 and 1966 which affect the administration of Soweto and other African townships, and which lay down rules and regulations pertaining to most aspects of life, including among other things mobility, education, land tenure, housing, transport, witchcraft, building trespassing, brewing of beer, marriage, and the settlement of labour disputes (Lewis 1969).

By 1930 most Africans lived in Western Native Township, in the slums of Prospect Township, and in the racially mixed freehold locations of Martindale, Newclare, and

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<sup>3</sup>The most notorious of these laws was known as the Influx Control laws. The Bantu (Urban Areas) Consolidation Act of 1945, with the 21 amending Acts passed in over the years, was the way urban Africans' lives were regulated. Section 10 of the law constituted that "no African may remain in a prescribed area for more than 72 hours (the onus of proof resting on him) unless he/she was born there, has worked for one employer for ten years or has been legally resident (which usually means continuous employment) for 15 years, and has in all three cases continued to live in the area" (Hellmann 1971:14).

Sophiatown (Mandy 1984:174). During this time the Johannesburg City Council decided to clear up slums and began to move Africans to Orlando, the oldest Soweto suburb (or township as it was known at the time). Orlando was founded on a farm Klipspruit No 8, 10 miles south west of Johannesburg (Carr 1990:2-3). All the so-called "black spots" were to be removed from areas in Johannesburg deemed as white. Seven thousand people were, for example, moved to Orlando from Prospect Township, then the Malay Location was moved and so on, until "smaller pockets were all cleared" and moved to Orlando (Carr 1990:7).

Over the next 20 to 30 years various housing projects were initiated in Orlando to cope with the housing shortage. This was the beginning of the notorious match box houses.

The house designs were simple and initially kept down to two or three roomed cottages, each with its own plot of ground, fenced, and with its own sanitation...To keep costs and rents down, no internal doors, floors or ceilings were provided, but each house was built of durable brick walls and with corrugated iron roofs (Carr 1990:5).

The African population of Johannesburg increased by 72% between 1936 and 1946, especially during the Second World War. By the end of the Second World War Orlando was totally overcrowded and many squatter camps sprung up in surrounding areas. More houses were built in Orlando, but that was not enough. Additional areas such as the Moroka Emergency Camp and Shanty Town had to be organized in the same year. The forced removals in 1955 of Africans from Sophiatown and Newclare to Meadowlands and Diepkloof prompted the Johannesburg City Council to build 50,000 houses, 88 schools, 3 hostels and some other facilities between 1954 and 1960 (Diadla et al.1994:8). By 1970 Soweto included 26 townships (suburbs) - today all well-known suburbs of Greater Soweto.

When the Bantu Affairs Act was passed in 1971 the Greater Soweto was separated from the administration of the Johannesburg City Council. Shortly after that the West Rand Administration Board was created and took over control of Greater Soweto. In the 1980s Sowetans were allowed to establish town councils but these councils never gained credibility because they were fiercely opposed by the black consciousness movements.

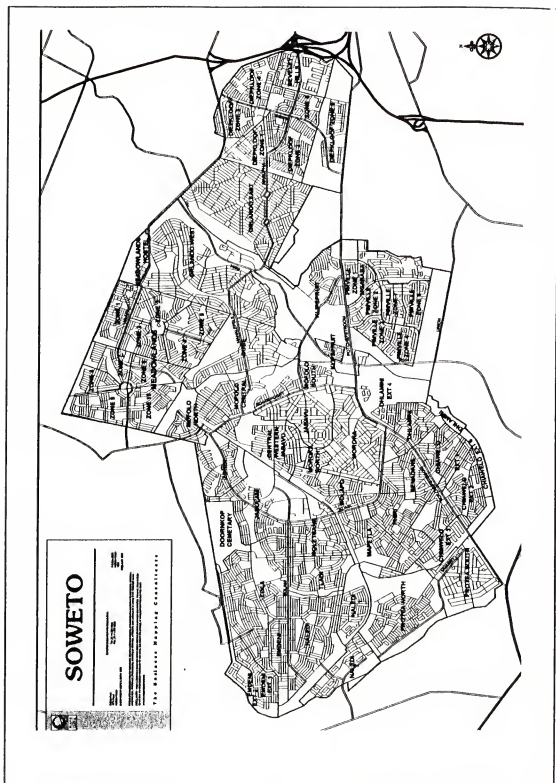
Ten years later, in 1991, the administration of Soweto was in a “real chaotic state” (Dladla et al. 1994:8). Soweto has only recently, after the change of government in South Africa and after local municipal elections in 1995, become part of the Greater Johannesburg Transitional Metropolitan Council, the new local government structure for the Greater Johannesburg area.

### **The People and Characteristics of the Research Sample**

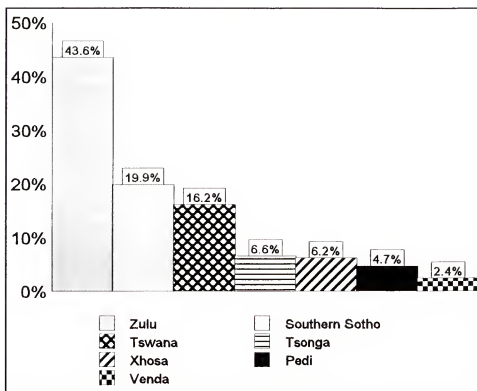
Soweto rapidly grew over the years to an estimated population to be 1.2 million in 1995. Density is high, with about 125,000 formal housing units, 3,400 flats, 8,500 outside rooms and garages used for lodging, and 37,000 beds in hostels (Chris Steele Architects and Associates 1993). There are 16 informal settlements in Soweto, with more than 14,000 temporary structures in these settlements (Daponte 1995:11). The sample for this study included women living in all these different housing types.

You cannot talk about Soweto without talking about variety. West (1975:15) paraphrases Hellmann saying:

...Soweto shows also a diversity of people of different languages and backgrounds and attitudes. Soweto mirrors many of the changes taking place in African society; its citizens include people of conservative, rural background and highly sophisticated urban-dwellers and there is a growing differentiation, in socio-economic terms, among its population.



For example, South Africa's 11 official languages are all represented in Soweto. The sample for this study includes a variety of African languages (Figure 2). Zulu was the most commonly spoken language (43.6%) and the three Sotho languages (Sotho, Tswana and Pedi) the second most common (40.8%). The rest of the women speak Xhosa, Tsonga and Venda.



2 Women in the Soweto Sample's First Language

Language differences often suggest cultural variation but most of the women (83%) would not indicate a specific cultural influence on their family life. It was clear from the interviews that the women's views on the use of medicines integrated many diverse cultural ideas, a reflection of the diversity and borrowing of ideas in Soweto.

Although the different Soweto townships were initially mixed in ethnic groups, by 1955 it became obligatory to zone all South Africa's African townships for different ethnic groups. Soweto was then also zoned. In 1971, according to Hellmann, there were 10 predominantly Nguni<sup>4</sup>, six predominantly Sotho<sup>5</sup>, one Sotho/Nguni, one Venda/Shangaan and 8 mixed townships (Hellmann 1971:4). This practice continued for many years so that certain suburbs are more representative of particular ethnic groups than others. Although neighborhoods are increasingly mixed, people from the same language group often cluster together in areas. In an example of seven Soweto yards<sup>6</sup> (Figure 3), you can see that the inhabitants of every yard share the same language and cultural connections, although as neighbors they speak a variety of languages.

"Yard" is also the unit I used to select the sample (Chapter 6). All the yards chosen as an example of what different yards look like are in a section of Diepkloof, Soweto. They illustrate the differences in housing types and household composition very well. Family composition varies considerably and households are relatively small. Hellmann's observation from the late 1960s is still true. She writes that "...the main characteristics of the Soweto household are clearly, compared with the traditional homestead, small in size (six or fewer members), that in composition it is approximating the modern family..." (Hellmann 1971:12).

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<sup>4</sup>Zulu, Swazi, Xhosa and Ndebele.

<sup>5</sup>Southern Sotho, Pedi and Tswana

<sup>6</sup> A yard is an enclosed area or clearly marked ground with one or more structures on it. The space is shared by one or more households. The concept of yard was used to ensure that all the households in Soweto had an equal chance of being selected for the study.

Data from the Birth to Ten<sup>7</sup> longitudinal study confirm that the average Soweto household still has six or fewer household members in the 1990s.

Although the majority of Sowetans live in formal housing (mostly small two, three or four room houses), almost every house has a backyard structure. This is typical of poorer areas where there is an acute housing shortage. Backyard lodgers, family, friends or acquaintances all pay and are a valuable source of income. This seems to have been the situation since the 1930s. Writing in 1937 about conditions for Africans in and around Johannesburg Phillips (1938:93) remarks that: "sub-letting is resorted to in order to balance the family budget...".

Most people in Soweto have access to electricity, although coal is still commonly burned. Only a third of the houses in Soweto has indoor water; the most common source of water is an outdoor faucet. About two thirds of Sowetans use an outdoor flush toilet, pit or bucket latrine, while a third have an indoor flush toilet.

Although there are many businesses in Soweto most people work in and around Johannesburg and travel daily by train, bus or minivan taxi to and from work costing them around \$2<sup>8</sup> a day. In many ways, Soweto has remained a dormitory city.

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<sup>7</sup>Birth to Ten is a longitudinal child health and development study of more than 4000 children born in a 7-week period from April to June 1990 in Soweto and Johannesburg (Richter et al 1995).

<sup>8</sup> \$1=R5



**Yard 1:**

One 4 room house (2 bedrooms, a kitchen and living room). 1 shack in the backyard (1 room). Two brothers and their wives and 3 unmarried sisters live in this yard. They all share meals in the main house. One of the brothers and his wife sleep in the shack. They are all Shangaan speaking. No children.

**Yard 2:**

One 3 room semi-detached house (1 bedroom, a kitchen and living room)  
2 brick rooms in the backyard. A man and wife in the main house. Their 4 children live with family in KwaZulu-Natal. A married couple in each of the brick rooms. Both families in the brick rooms have houses in KwaZulu-Natal. Everyone in this yard speak Zulu.

**Yard 3:**

One 3 room semi-detached house (1 bedroom, a kitchen and living room)  
A single woman with a child live here by themselves. She is a Xhosa speaker from the Transkei.

**Yard 4:**

One 3 room semi-detached house (1 bedroom, a kitchen and living room)  
2 shacks in the backyard. One single man and a man and his wife in the main house. The couple's kids are living in Venda. The 2 shacks are rented out. One to a man from Venda whose wife lives in their house in Venda and visits him once a year. The other one to a man and his wife and one child. Everybody in this yard speaks Venda.

**Yard 5:**

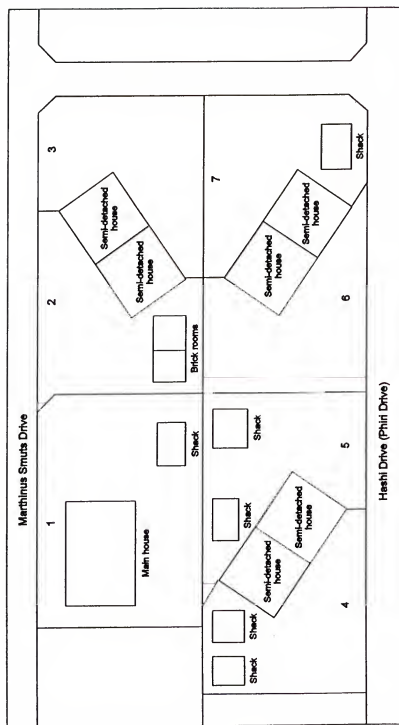
One 3 room semi-detached house (1 bedroom, a kitchen and living room)  
2 shacks in the backyard. Two elderly women (sisters) and 2 grandchildren live in the main house. The two shacks are rented out to a brother and sister respectively. Everybody in this yard speaks Shangaan.

**Yard 6:**

One 3 room semi-detached house (1 bedroom, a kitchen and living room)  
A man and wife, their daughter and her child. The child is being raised by the grandmother. They all speak Tswana.

**Yard 7:**

One 3 room semi-detached house (1 bedroom, a kitchen and living room)  
1 shack in back yard. Man and his wife in main house. Their 8 children are all staying in Giyani at their rural house. The shack is rented from them by a man, his wife and 2 children, who also own a house in Giyani. Everybody speaks Shangaan.



4 Example of Seven Yards in Diepkloof, Soweto

Official unemployment in Soweto varies between 30-50% (Steele 1993). Eighty percent of the women interviewed for this study had no form of employment, while the rest (20%) worked either in the formal or informal sector.

Many of the mothers were not married (63%), and lived with their parents. Many grandparents took responsibility (29%) for the financial support of the child, while 48% of the children's fathers contributed financially.

The population of Soweto is very young; for every 10 people of working age, there are 6 people too young to work (Daponte 1995:13). Women in the sample ranged in age from 14 to 43 years, with a mean age of 26 years. Twenty three percent of the women we interviewed were 20 years or younger, while 54% were between 21 and 30 years.

Much has been written about the notorious Bantu Education for Africans (Burman and Reynolds 1986). During the past 30 years Soweto children's education has been frequently disrupted because of the political situation in the country. Also, schools were extremely underfunded, understaffed, overcrowded and teachers often lacked education themselves. Some parents still sent their children to rural areas to go to school, while more recently many sent them to schools in suburban areas near Soweto where the education standards are perceived to be better. The women in the sample were relatively well educated in a South African context, with 55% of the mothers having completed Grade 10 or higher. Sixteen percent of the women had only a primary education. Table 1 displays the range of the women's education.

1 Mother's Education		
LEVEL	FREQUENCY	PERCENT
No education	6	2.9
Grade 1 or 2	2	1.0
Grade 3	0	0
Grade 4	2	1.0
Grade 5	3	1.4
Grade 6	11	5.2
Grade 7	9	4.3
Grade 8	21	10.0
Grade 9	42	19.5
Grade 10	39	18.6
Grade 11	33	15.7
Grade 12 ( Matric)	43	20.5
TOTAL	211	100

Hellmann (1971:9) quotes an unpublished 1966 survey of 175 Soweto households which indicated that only 15% of the respondents were born in Johannesburg, although the average length of stay of the sample was 22 years. She argued at the time that the people from Soweto are a people in transition from country to town and (their) "traditional culture is being changed by the impact of industrialization and modified by modern urban conditions". This is not true of this sample. Most of the women in this survey (81%) were born and raised in Soweto, while the rest of the women were from small rural towns and moved to Soweto, often early in their lives (Table 2).

2 Place Where the Infant's Mother Grew up		
PLACE	FREQUENCY	PERCENT
Homeland - rural	2	0.9
Homeland - small town	22	10.5
Small town	11	5.2
Township (Soweto and other townships)	171	81.0
City	1	0.5
Lesotho	4	1.9
TOTAL	211	100

The fertility history of the caregivers is illustrated by tables 3 and 4. The group of women that we interviewed had between one and eight pregnancies and between one and seven live births. The mean number of pregnancies and live births was two. Six women in the sample had a child who died and one woman had two children who died.

3 Number of Pregnancies		
NUMBER	FREQUENCY	PERCENT
1	94	44.5
2	50	23.7
3	30	14.2
4	18	8.5
5	13	6.2
6	3	1.4
7	2	0.9
8	1	0.5
TOTAL	211	100

4 Number of Live Births		
NUMBER	FREQUENCY	PERCENT
1	97	46.0
2	54	25.6
3	30	14.2
4	16	7.6
5	8	3.8
6	5	2.4
7	1	0.5
TOTAL	211	100

5 Infants' Ages		
AGE	FREQUENCY	PERCENT
< 1 month	20	9.5
1 month	33	15.6
2 months	12	5.7
3 months	18	8.5
4 months	17	8.1
5 months	20	9.5
6 months	19	9
7 months	17	8.1
8 months	15	7.1
9 months	11	5.2
10 months	12	5.7
11 months	11	5.2
12 months	6	2.8
TOTAL	211	100

Mothers who were interviewed for the study had infants aged 12 months or younger (Table 5). Their ages vary from a few days to 12 months old. The average age of the children whose mothers were interviewed was five months. There were 47.9% boys and 52.1% girls in the sample. Many of the children in the sample were either first borns (46%) or second borns (26%).

### Summary

Soweto, the site of the sample, is a diverse environment where different African cultures and ethnic groups have been thrown together for more than 60 years. People from the area have been borrowing and exchanging ideas over this period so that cultural practices are now a potpourri of different African cultures. The 211 women in the sample reflect this diversity.

## CHAPTER 6 RESEARCH DESIGN AND METHODS

### **Types of Data Collected**

Although specific research methods to study the provision and use of pharmaceuticals in developing countries are relatively limited, researchers can choose from the variety of anthropological methods available. Most researchers of pharmaceutical products seem to make use of questionnaires or secondary material because qualitative methods such as participant observation, in-depth interviews or focus groups are considered time consuming and not very practical (Report on the International Conference on Social and Cultural Aspects of Pharmaceuticals 1991:9).

Researchers agree that a wide perspective is needed for the study of pharmaceutical products in developing countries. In order to have this perspective, researchers should include a combination of quantitative and qualitative methods, as well as combine macro and micro analysis (Report on the International Conference on Social and Cultural Aspects of Pharmaceuticals 1991:5; Whyte and Van der Geest 1988:8). Macro and micro level perspectives could be complementary: macro analysis examines policies at the national and international level, while at the micro level analysis studies of pharmacies, household use and individual use provide insight into popular perceptions and practices. In addition, looking at medicines in a historical context provides a general



framework for understanding their use, the historical processes and changes in social relations.

In an effort to provide a historical context (international, national and, local) for this study on over-the-counter pharmaceutical products, I combined different methods:

- a. a survey of relevant literature, including grey literature, such as consumer advocate reports, and archival material such as user pamphlets and advertisements;
- b. a collection of different kinds of medicines, containers, package inserts, medicine boxes, and some containers of the boxes;
- c. A visits to pharmacy museums
- d. observation at pharmacies, general stores, stores specializing in African medicine, and street vendors;
- e. open-ended interviews with government officials, pharmaceutical representatives, and consumer advocacy groups;
- f. small group discussions; and
- g. interviews with a random sample of 211 primary caretakers of children 12 months old or younger in Soweto using a combination of structured, and open-ended questions.

### **Literature Survey**

Bernard (1994:118) points at three useful sources to get started on any project: knowledgeable people in the field, review articles and bibliographic search tools. In addition to searching the catalogues of several libraries on-line, I searched the Social Science Citation Index and Medline for books and articles on pharmaceutical products,

medicines, and theoretical input on Pharmaceutical Anthropology. This immediately led me to a few key sources: two review articles from 1987, 1990 and an edited volume by Van der Geest and Whyte 1988. I later found a review article in the 1996 Annual Review of Anthropology as well as another edited volume on a conference on Pharmaceutical Anthropology. Much of the literature came from "obscure" journals and other sources. Because of the concentration of interest in The Netherlands many of the articles and user pamphlets consulted are Dutch.

Critical literature on the pharmaceutical industry is often "grey" literature and only available from the organizations themselves, for example the large number of publications by Health Action International (HAI) in Amsterdam. A visit to the University of Amsterdam in 1995 and the office of HAI proved to be very helpful. Prof Sjaak van der Geest allowed my to spend a day looking through their database and copying documents from their files. HAI provided me with several important documents.

### **Informal Discussions**

I used informal discussions with individuals and groups of women at the Chris Hani Baragwanath Hospital in Soweto over a period of three months before starting the project. These women who all had small children, were waiting to be interviewed for the Birth to Ten project. They had diverse cultural and socio-economic backgrounds and were representative of people living in Soweto. In these discussions I familiarized myself with the vocabulary used to talk about the various kinds of over-the-counter products that are used for infants and why they were used. I asked the women to tell me the names of the products they use, where these were purchased, what conditions they were used for, and

how they were used. I also asked them to describe different kinds of children's illnesses making notes on the indigenous terminology. The spontaneous and informal discussions sometimes involved only one person but most of the time were with a small group of women.

Although I mostly used English as the conversation medium, some of the women were more comfortable using an African language. In those cases a research assistant translated the conversation both ways. I used the information from these conversations to compile a list of the different kinds of medicines that are commonly used for infants. It soon became clear that the majority of women were using OTC products for their infants. I bought every product that was on the list and started to bring the products into the informal discussions.

The group discussions were especially useful for the reasons Scrimshaw and Hurtado (1987:15) suggested:

- To focus the research and help researchers to formulate questions for a formal interview questionnaire;
- To supplement researchers' information on community knowledge, beliefs, attitudes and perceptions about health and health resources;
- To help researchers to develop research hypotheses for additional studies;
- and
- To develop appropriate vocabulary for health education programmes.

### **Observation**

Observation is an important part of anthropological fieldwork. It involves interacting with members of the local community, observing their actions both as insider and outsider. As an "insider" the researcher should try to understand the local point of view about medicine use and "the particular cultural meaning and type of social transaction that seems

'natural' to the people involved. As the 'outsider' the researcher should try to understand medicines used by "comparing those conceptions and arrangements to other" (Whyte and Van der Geest 1988:8).

Some of the advantages of observation for the study of medicines are that you can gather data on which medicines are being sold, prescribed or used, what kinds of information the seller or doctor provides, and whether drugs are purchased on prescription. Interviews with all the relevant people (prescribers and consumers) can then supplement the observations. But there are disadvantages. Your presence could make people suspicious and may prompt them to conduct business in a different way, a more "correct" way. Doctors, pharmacists and health workers may feel that you are testing their competence" (Hardon et al 1991:12). The crucial point in the study of medicines is for the researcher to get involved in the local situation of how people sell, buy and use medicines, in order to really understand what is going on (Whyte and Van der Geest 1988:8).

My observations included visits to chemist stores, retail stores, spaza shops, street vendors, African medicine stores, and the Mai-Mai store in Johannesburg where indigenous healers sell their products. I bought medicines and had conversations with sales attendants. One interesting observation is that when I asked for a Dutch medicine product or Muti Wenyon in a pharmacy in a predominantly "white" area, a black shop assistant was always called to assist me. In some cases the assistant proceeded to give me advice on how to use the product for my child. The assistants act as the unofficial pharmacists and experts on "African problems" and African medicines in many of these pharmacies.

## Sampling

I decided to interview the consumers of over-the-counter products at their homes and to randomly select women with infants that are 12 months or younger. Because the precise size of the study population, all mothers with children 12 months or younger living in Soweto, was unknown, the sampling was done by using a 35 by 6 cluster sampling method (Henderson and Sundaresan 1982). This method is frequently used by the World Health Organisation in places where the total population is unknown. A map of Soweto was divided into 4 x 4 cm blocks. Thirty five blocks (clusters) were randomly selected and a starting point in each cluster was then randomly selected. The interviewer went to every 5th yard in each cluster and randomly selected a woman with a child 12 months or younger who permanently lived in the yard.<sup>1</sup> If there were no children 12 months or younger in the yard or if there were people who declined to participate, the research assistant moved clockwise in the street, skipping four yards and tried the 5<sup>th</sup> yard until she completed 6 interviews in the cluster. This process went on for five months.

## Interviews

Structured interviews are often used to interview either drug providers or consumers on issues including prescription practices, treatment of illnesses, drug purchases at pharmacies, including prices and over the counter sales of prescription drugs. This provides data that can easily be quantified and compared with the results of

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<sup>1</sup> For detail see "How to choose the respondent" in Appendix A.

other studies (Hardon et al 1991:10). It is important to complement structured interviews with interviews that provide more qualitative data.

I decided to ask about current medicine use because the literature indicates that the most reliable information on medicine use is gathered when you cover short periods of time. Schulpen and Swinkels (1980) for example found 60% under-reporting of self-medication when the recall period was two weeks instead of one day (Hardon et al 1991:11).

The interview style was completely open and informal to encourage the Soweto women to give us as much information as possible. Africans are often reluctant to discuss indigenous health belief systems because of the prejudice they usually experience in the bio-medical sphere.

From September 1994 to January 1995, a sample of 211 Soweto mothers with infants 12 months or younger were interviewed about their use of over-the-counter medicines. We used a questionnaire to collect quantitative as well as qualitative information (Appendix A). This questionnaire included questions on the over-the-counter and folk medicines mothers were using for the identified child and was pretested in Soweto. I decided not to tape record the interviews as this might have been viewed as too invasive.

The research assistant explained the project to every selected person and obtained her verbal permission before the interview started. We pointed out that the person's identity would be kept anonymous and that we would not record anybody's name on our questionnaires, and only a study identity number. The first part of the interview was the collection of basic socio-demographic data on each respondent. Box covers of all the medicines our preliminary observations and inquiry had indicated as being used by

mothers, were carried in a little suitcase. The person was asked to use the boxes and divide them into two piles - those used and those not used for the child. If she had other medicine in the house that she was using, the research assistant asked the woman to add it to the pile. The assistant then took each medicine or group of medicines and asked the woman a series of questions using a list of open-ended interviews:

- a. the types of medicines used;
- b. the conditions that each medicine is used for;
- c. the reasons for using each kind;
- d. the frequency and total duration of the use for each medicine
- e. a list of side effects or precautions needed for each medicine
- f. the source of information on each medicine
- g. the place where each medicine was obtained.

The duration of the interviews varied depending on the number of medicines but was usually around an hour. We reviewed these questionnaires once a week. Interviews were conducted on weekdays, as well as on weekends to ensure that we included working women in the sample.

There are obvious advantages when the researcher can conduct all the interviews personally. However this becomes very difficult when there exists a language barrier and/or access in the research area is restricted for reasons of personal safety. The alternatives were to work through an interpreter or use an assistant. I decided on a Soweto resident, Ms Seipati Choene, whom I know well and who had more than 6 years experience as a health research assistant. She is familiar with all 11 official languages of South Africa.

All the interviews were conducted and recorded on paper in the preferred language of the respondent for example, Zulu, Tswana and so on. Afterwards the interviews were translated into English. This was done to ensure that cultural concepts and expressions relating to the use of the pharmaceutical products were captured. Ms Choene, Ms Mantoa Langa (a Birth to Ten research assistant) and went through each questionnaire. We translated over 400 individual sheets of information. I added explanatory notes as we were translating and discussing the data. I also tape-recorded some of our conversations.

### Study Documents

I collected different kinds of documents to analyze for the study: package inserts, box covers, advertisements, Acts of parliament, and signatures from a petition on Dutch medicines from Parliamentary library. I consulted new and old pharmacopeia and used the World Wide Web to gather information on the South African pharmaceutical industry.

Archival material included pamphlets, advertisements from SA library in Cape Town, Johannesburg Public Library and the libraries of the University of the Witwatersrand and Pretoria as well as a visit to Oudtshoorn's CP Nel Museum which has a Lennon pharmacy intact and several examples of *huis-apotheek*s. I also visited the museum of the Transvaal Pharmaceutical Society in Johannesburg and interviewed the curator.



## CHAPTER 7 PROTECTING VULNERABLE INFANTS: SUMMARY OF AFRICAN HEALTH AND HEALING CONCEPTS IN SOUTH AFRICA

### Introduction

Concepts of health and healing are constantly changing. In South Africa changes have to be viewed against the background of colonialization and industrialization that stretches back for more than 300 years. During this time the ideas of the different cultural groups changed continually because of movement and borrowing, intermarriages, urbanization, and intermingling of languages and ideas. The cultural borrowing did not only take place between different groups of Africans, but also between Africans and the white settlers who came from different regions in Europe, Africans and the Khoi, and later between Africans and the different groups of mixed descent (mixtures of Khoi, eastern slaves, Africans, Europeans). Borrowing ideas became even more common when people began to move to urban areas where languages and cultures came in close contact. Although there is always some persistence of past beliefs many African beliefs have been modified and changed to fit the both new conditions and new illnesses, especially those encountered in the urban areas. And although many Africans adopt bio-medical concepts and treatment, they still retain some traditional concepts when they find it "necessary to impose significance on their existential experiences" (Hammond-Tooke 1989: 10).

It is important to understand that, as Hammond-Tooke (1989:32) points out, ideas and practices associated with healing are part of a "wider system of concepts that

underlies and reflects perceptions of the world and of humanity's place in it". Therefore ideas about health and illness always have close links with religious systems and world-view. All humans have a need to try and explain why something happened: "Why me?". We all need to allocate responsibility. World-view and religion provides us with a set of logical ideas that enables us to answer this question.

Hammond-Tooke separates the world-view of the South African Bantu-speakers into four broad sets of theories to explain the "human condition": A supreme being, ancestors, witches and pollution beliefs (1989:46). These are the four agents that can cause serious illness. The illnesses connected to any of these agents are "diseases of the African peoples". Ngubane argues that the term "African disease" is used:

mainly because the philosophy of causality is based on African culture; this means not that the diseases, or rather their symptoms, are seen as associated with African peoples only, but that their interpretation is bound up with African ways of viewing health and disease (Ngubane 1977:24).

In addition to explaining health and illness in terms of these four related sets of ideas, there are also illnesses that "just happen" or illnesses whose origin is related to the relationship between humans and their environment. There is a range of illnesses believed to "just occur" or "just come" for example colds, coughs, measles and so on, all explained in natural terms, as they are not "sent" (Krige and Krige 1956:222; Hammond-Tooke 1989:56-57). What is perceived as a "natural" illness is of course culturally constructed and does not necessarily coincide with western notions of natural.

In this chapter I will summarize the general concepts that are most widely shared by Africans in South Africa and then specifically focus on infants, their vulnerability and need for protection as described in different southern African ethnographies.

## Humans and Their Environment

There is a popular belief that all African illnesses are in some way associated with supernatural causation. This is not the case. Many illnesses are in the category of "it just happens" or are part of the natural environment.

Diseases in the category "just happen" are associated with growing up, for example measles, mumps or problems during teething. Ngubane (1977:23) tells us that seasonal changes can cause these "natural" kinds of illnesses such as diarrhea and hay fever. Some families are prone diseases like epilepsy and chronic chest complaints. None of the natural diseases are the result of malice or the fault of the sufferer: they just happen. These diseases are treated with potent, but non-ritualized medicine (Ngubane 1977:23).

Ngubane (1977:24-29) also describes another level where natural forces operate. This has to do with the relationship between a person and the environment. Although she talks about Zulu beliefs, similar ideas are held by other ethnic groups in southern Africa. Understanding these ideas is important for understanding the reasons why Soweto mothers find it so important to use medicines for protection and strengthening of their infants.

There is a general belief that both humans and animals leave something of themselves behind when moving around and absorb things from the atmosphere through which they move. What is left behind is called *umkhondo* (track) in Zulu and *mohlala* in Sotho. *Umkhondo* usually refers to visible tracks on the ground but can also be a reference to invisible tracks like what dogs can detect. If the last kind of "tracks" are floating in the air it is called *imimoya*<sup>1</sup>. People can inhale *imimoya* (*uhabula imimoya*) but

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<sup>1</sup>Moya means wind, air breath.

step over *imikhondo* (*weya imikhondo*). Some of these tracks can be harmful or "bad" in which case the adjective *emibi* is added for example, *imimoya emibi* (bad "spirits"). Soweto women described *imimoya* not as "tracks" floating in the air but as "spirits" floating in the air.

There are also all kinds of undesirable elements in the atmosphere that are picked up through inhalation<sup>2</sup> or through contact either by touching or "stepping over".

In "stepping over" (*ukweqa*) or contact by touching, the joints of the bone structure are said to be the most vulnerable points through which evil elements enter the body. Hence in prophylactic treatments incisions are made on the joints in order to introduce medicine directly into points where the body is most at risk (Ngubane 1977:25).

Some kinds of wild animal tracks or spoor (*imikhondo yezinyamazane*) are believed to affect infants who inhale them. However, because of regular medication against "*imikhondo*" of wild animals a baby slowly develops "immunity" and by the time it reaches childhood it is usually immune (Ngubane 1977:25). Adults also can carry this kind of *unkhondo*, for example nursing or pregnant women can pick up *imikhondo* that causes a baby to become sick.

Naturally caused diseases (*Imkhulane* diseases) are identified by their symptoms while "diseases associated with ecological dangers are identified primarily by the nature of causation rather than by the symptoms" (Ngubane 1977:25-26). It is therefore important to identify the cause of an illness and correct it because only treating symptoms are useless<sup>3</sup> (Ngubane 1977:26). The environment becomes even more dangerous when

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<sup>2</sup>I use the Sotho word *gabola* for "inhaling" in Chapters 8 and 9.

<sup>3</sup>This is a reason why combining bio-medicine (to treat the symptoms) and indigenous medicines (treating the cause) remains popular in South Africa.

people rid themselves of certain kinds of diseases because the diseases may hover and get attached to another person especially at cross-roads and highways<sup>4</sup> (Ngubane 1977:26).

According to Ngubane the environment is full of dangers:

The environment is not only polluted by undesirable tracks or by what is discarded in healing. It is also made dangerous by sorcerers, who place noxious substances on a particular person's pathway or scatter them along pathways to harm any passers-by, with a condition of *omeqo* (Ngubane 1977:26).

Therefore if you want to survive all these dangers you have to be frequently strengthened to build up and maintain resistance. This is achieved by establishing and maintaining a form of balance with the surroundings. This balance is needed not only between humans and their environment, but also between individuals (Ngubane 1977:26).

If a person uses very strong medicines to establish this balance, when he meets someone who is not properly strengthened, the latter is overpowered by his presence and may become ill. This is known as *ukwekha ngesithunzi*, to feel or suffer the weight of someone's overpowering influence (Ngubane 1977:26).

Although there is no Zulu word which means "balance" the notion is implied by other words meaning "to put to order, arrange, adjust, set as it should be, tidy, state of being in order" and so on (Ngubane 1977:26). The English word "balance" can be used to mean "moral order" - the position of people vis-a-vis other people, the environment, ancestors, and other forces that produce pollution. The idea of balance is the "pivotal ideology" around which revolve most of the ideas that "constitute what is known as African diseases (*ukufa kwabantu*)" (Ngubane 1977:27). "Good health means the harmonious

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<sup>4</sup>In Soweto the areas near hostels are also considered dangerous because of the belief that people living in the hostels vomit regularly after taking strong African medicine.

working and coordination of his universe" - health is not just a healthy body, but a complete harmonious environment. Illnesses are considered to be the result of disequilibrium and disharmony.

Some people are more vulnerable than others to environmental dangers. These include infants, strangers in the area, or people who have allowed too long a time to pass between treatments. It also includes people who are considered to be polluted.

An infant is not only a stranger to the environment. It also has a fragile bone structure, with wide joints, such as the fontanelle (*ukhakhayfi*), which is considered a weak point against the hazards of the environment. In order to survive, the baby must be protected even before it is born. Its mother must observe a pattern of behaviour that will minimize contacts with *imikhondo*...She should not allow long periods to elapse between strengthening treatments (Ngubane 1977:28).

Ecological factors are the primary cause of a wide variety of illnesses, some insignificant others fatal. For example,

when baby cries continuously, or when it is fretful or shows a general debility, it is said to suffer from *inyamazane*, i.e. the effects of certain wild animal tracks. Green diarrhoea and coated tongue are said to be symptoms of contaminating lighting fumes from an area recently struck by lightning. The condition is known as *inyoni* (bird), as it is believed that lightning strikes in the form of a bird (Ngubane 1977:29).

These environmental factors (inhaling, stepping over spoor, and *inyoni*) are very important reasons for protecting and strengthening babies in Soweto. My discussion will return to these topics in the following chapters.

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<sup>5</sup>Phugwana in Sotho.

### Supreme Being

Most pre-Christian groups had only a vague concept of a creator and there were no rituals or prayers specifically directed at this being (Hammond-Tooke 1981a:84-86). People only resorted to god as an explanation when nothing else could explain the event (Hammond-Tooke 1989). This changed with the introduction of Christianity and people now use God as an explanation for illness in varying degrees. The notion of a wrathful (Christian) God using illness as a punishment or letting illness happen is one of the reasons why faith healing has become very popular in South Africa.

### Ancestors

The spirits of deceased ancestors have a very important place in the world-view of Africans because they are responsible for looking after the interests of their descendants. The presence of ancestors is an important factor in maintaining good health.

Their influence is essentially benign and all-embracing, for they are present at all times, 'brooding' over the homestead and following their descendants wherever they go, for, unlike the case with witchcraft, which operates only over short distances, ancestors are ubiquitous and follow their charges everywhere - even into urban areas (Hammond-Tooke 1989:63).

In other words, they are ever present and everywhere. Although not common, and seldom fatal, they can send illness and misfortune if moved to wrath (Hammond-Tooke 1989:47). The ancestors will trouble the living if they:

- a. neglect "customs of the home" - the necessary rituals at important life cycle points such as birth and death, thanking the ancestors after finishing a task or journey or after an illness; and
- b. failure to respect seniors (Hammond-Tooke 1989:47;64).

Ngubane (1977:51) says that the ancestors are mainly "concerned with the welfare of their descendants". They are "with people" when good things happen, but can withdraw their "protection and gifts of good fortune from erring descendants. Without their protection the descendants become vulnerable to all sorts of misfortune and disease".

Krige and Krige, writing about the Lovedu, explain that:

disease and healing are in the last resort connected with the guardianship of the ancestors. If they are annoyed and relax their vigilance, their descendants may be rendered susceptible to disease, or medicines used cannot have their full effect. Ancestors, however, do not merely ward off disease or assist cure; they also actively cause illness. The crying all day of a baby may be due to the spirit of a grandfather pinching it in order that it should be given his name; sore eyes in children are often, and in adults sometimes, attributed to ancestors... (Krige and Krige 1956:222).

### Sorcery or Witchcraft<sup>6</sup>

Hammond-Tooke (1989:73) describes witchcraft as the "mystical ability to cause harm to others believed to be possessed by certain individuals" changing shape, becoming invisible, sending agents (familiars) to do evil deeds. It is the belief that certain individuals driven by envy or malice send familiars to harm others. A witch can be anyone, especially kin or neighbors.

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<sup>6</sup>The terms witchcraft and sorcery are often used interchangeably in older ethnographies and refer to "any act of harmful magic" while in fact, many groups of people often make conceptual and linguistic distinction between them (Malefijt 1968:271). Evans-Prichard distinguishes between witchcraft ("implying the use of the witch herself, or a familiar, as an agent of destruction") and sorcery ("the use of medicines, including poisons"). "Witchcraft is the belief that certain persons, usually through motives of envy and malice, have the power to harm one. This can be effected either by means of familiars or through the use of medicines and poisons" Although the distinction is not always clear the first is called witchcraft and the second sorcery.



In the Sotho cultures (Tswana, Pedi and Southern Sotho) the term *baloi*<sup>7</sup> (sing. *molo*) is used to refer to sorcerers who employ magic to cause illness and misfortune to people and their property. Both the Kgaga (Hammond-Tooke 1981a:96-97) and the Tswana (Shapera 1976:65) distinguish between two types of baloi: there is the *baloi ba motshegare* (sorcerers by day) and the *Baloi ba bosigo* (sorcerers by night).

Ngubane (1977:31) on the other hand describes three kinds of sorcerers in Zulu culture: night sorcerers, day sorcerers and lineage sorcerers. A night sorcerer resembles the conventional concept of witch described in many African societies. The Zulu stereotype is always a man that harms people for no apparent good reason, keeps baboons as familiars and visits homes at night to perform evil acts, rides naked on a baboon, digs up corpses and transform them into dwarfs under his control. He is mean, jealous and keeps to himself. His chief technique is "to scatter and bury noxious medicines in the homes of his victims" (Ngubane 1977:31). He will also throw medicines along roads to harm any passerby and "he is a danger to the community at large and is feared...because he...renders the environment dangerous for his victim, or puts people out of balance with their environment" (Ngubane 1977:32). People can be harmed by this medicines if they "step over" it or if they are not properly strengthened.

The second kind, the day sorcerer is regarded as sorcerer not by the community at large but only by those with whom he/she is in conflict. This kind of sorcerer could be a man or a woman (Ngubane 1977:35).

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<sup>7</sup> *Balôyi* (sing. *molôyi*) (Pedi).

The third kind is a lineage sorcerer and among the Zulu can only be a man. He is someone who deprives his victim and dependants of the protection of their ancestors (Ngubane 1977:36).

All these sorcerers use medicines. Ashton (1943:5), writing about the Southern Sotho, notes that sorcerers have two kinds of medicine: some that are capable of only doing harm, and others that are special medicine, like *setipi*, *mohato* and *mohlala*, which are normally used for benevolent ends but become noxious when used with malevolent intent (Chapter 8 for more detail). There are several methods of protection against sorcery. Most people have their bodies "strengthened" by an indigenous doctor or buy medicines to protect themselves<sup>8</sup>. Buying your own medicine to protect yourself has become more and more popular as Muti shops began to package and promote protective medicine and as some pharmaceutical products started to take on protective value (for example *Muti Wenyon*i and Dutch medicines). Sheddick already noticed this trend in 1953: "Throughout southern Africa medicines<sup>9</sup> may now be purchased by anyone from large mail-order "pharmacies" in Johannesburg and elsewhere" (Sheddick 1953:72 fn).

### Pollution Beliefs

Some forms of illness and malaise are caused, not by wrath of ancestors or machinations of witches and sorcerers, but because people find themselves, often inadvertently, in a state of ritual impurity (Hammond-Tooke 1989:50).

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<sup>8</sup>The Zulu use *intelezi*, a protective medicine or protective charm.

<sup>9</sup>Meaning protective medicine.

People in such a state include widows, women who had an abortion, twins, or people back from a long journey. In southern Africa pollution is associated with dirt and darkness (Zulu) or heat (Sotho). Illnesses associated with a state of pollution are not sent by a person or spirit but are inherent in certain life conditions and therefore the result of impersonal causation (Hammond-Tooke 1989:50).

Pollution beliefs should be separated from ancestor and witchcraft beliefs because they do not involve "the actions of intelligence, whether human or 'spiritual'", but are the result of "impersonal causation", and "appear to have little direct association with morality" (Hammond-Tooke 1981b:16). The ancestors' vexation is your own wrongdoing for neglecting the necessary rituals, and misfortune caused by witches is the "result of emotions of envy and malice emanating from close associates who wish to do harm because of one's success" (Hammond-Tooke 1981b:16). Pollution typically involves a ritual state "which can contaminate through no fault of one's own and, frequently, the danger is believed to be greater for others than for the polluted person himself" (Hammond-Tooke 1981b:17).

There are differences in how pollution is understood in southern Africa. For the Sotho groups pollution is "heat" that must be cooled by water, ash, chyme and soot. For the Zulu pollution is darkness or "blackness" that is cleansed by white medicines. Thus, the Zulu reaction to pollution is cleansing while the Sotho reaction is cooling. Ngubane says the Zulu notion of pollution (*umnyama*) is

conceptualized as a mystical force which diminishes resistance to disease, and creates conditions for poor luck, misfortune (*amashwa*), 'disagreeableness' and 'repulsiveness' (*isidina*) whereby the people around the patient take a dislike to him without any provocation. In its worst form *umnyama* is contagious (Ngubane 1977:78).

These pollution beliefs are closely associated with birth and death. Thus a woman that has just delivered a baby is very dangerous to herself, to her baby, and to men.

For the Sotho speakers pollution means "to be hot" (*go fiša*):

Babies also suffer *fiša* from what is called 'fontanelle trouble' (*hlôgwana*), a depressing of the fontanelle which can be caused by dehydration due to malnutrition or feverishness, in which, it is said, the body becomes sore and feverish, causing the baby to cry a lot. The usual cure for this type of *fiša* is medicinal, especially the use of the acid-tasting leaves of a small evergreen bush called *mokgalakane*, boiled in water and given to the patient to drink (Hammond-Tooke 1981a:113).

The state of hotness must be cooled.

For an infant in this condition herbs are mixed and smeared on the patient's head, armpits, groin, palms, soles, chest, back and stomach. As a prophylactic *dilwane* and *polao* roots are chewed very early in the morning and spat into the gourd... (Hammond-Tooke 1981a:116-117).

According to Hammond-Tooke (1981a:113-116), writing on the Kgaga (and other Lowveld Sotho) beliefs, being polluted (*fiša*) is associated with conditions surrounding: death in general, with the death of a chief in particular, sexual contact, birth of twins, mourners, pregnant and menstruating women, a man handling a corpse, miscarriage, young girls in their teens, the initiation lodge of young boys, someone from a journey, or angry ancestors (*badimo*).

The differences in these pollution concepts are illustrated by an example of *inyoni*, a "highly prevalent, and severe, infantile gastroenteritis". Hammond-Tooke's students reported on methods of prevention:

Among the Zulu the child is taken out into the veld and given an enema: among the Sotho a broom is hung outside the house to warn away widows or menstruating women, who may cause *inyoni* (Hammond-Tooke 1981b:13).

## Protecting Infants

The foregoing presentation indicates there are many potential threats to the life of a new born baby. These include “inhaling” things or “stepping over” things in the environment, problems with God and the ancestors, the maliciousness of the *baloi* (witches) and contact with polluted people. A baby will stay vulnerable for many months after birth. To ensure the child’s survival and continued health, parents, especially the child’s mother, need to take special steps and perform certain rituals. These steps, which begin while the woman is pregnant, include avoidance of potentially dangerous situations, the performance of certain rituals immediately after the birth, as well as the maintenance of specific daily or weekly rituals.

Although there are many variations, most ethnographers describe a similar situation for every newborn baby’s first few months. The afterbirth is carefully buried. As soon as a baby is born the midwife must make sure that it cries, the cord must be cut and disposed of, the baby must be able to swallow and be fed, must be bathed, protected from potential harm by secluding it for a period, as well as protecting it with medicine. If harm is not avoided or certain protective actions not preformed, the baby will fall ill and die.

Many of the customs and rituals described below are not closely followed in Soweto anymore, but are present as variations and adaptations.

### Afterbirth

Great care is exercised to dispose of the afterbirth either by secretly burying it or by getting rid of it in any way that would assure that it did not get into the hands of strangers or witches who could use it to endanger the life of the child (Ashton 1952:28;

Krige 1950:66; Van der Vliet 1974:214). Traditionally the afterbirth was buried in the hut or in the courtyard. This practice became difficult in urban areas with cement floors and crowded homes. Hellmann describes a situation in Rooiyard where the mother asked the midwife to cut up the afterbirth and flush it down the toilet (Hellmann 1948:58). Women in Soweto currently seldom deliver at home and hospital personnel dispose of the afterbirth in an incinerator.

## Crying

Although there are very few southern African ethnographic references to the importance of a child's first crying, Mönning (1967) does mention that the Pedi believe that a child should cry after birth as a sign that it has a soul (*moya*). If there is no immediate crying the child is slapped with the hand or with a corn-stalk.

Crying is a mother's cue to her baby's well-being and initially her main source of information about her baby's needs. Jali (1950:17) tells us that a mother's first thought when her baby cries is that the child is hungry and that "the father too, cannot tolerate baby's screams... If not attended to at once, the mother is often accused of negligence". A mother is thus responsible for keeping a baby content and quiet.

A 1994 study by Richter on early child care in Soweto suggested that most mothers interpret infant crying as the result of hunger and that mothers' "responses to infant crying are based on a generalized assumption that infants do not cry without cause" (Richter 1994:22). There is considerable pressure on mother's to keep their babies from crying a lot, especially in big households confined to small spaces, as is usually the case in Soweto. Richter points out that a "substantial proportion of mothers appear to have unrealistic expectations regarding normal crying patterns in young infants" and that "82%

of women thought that their babies cried less than the norm, which may indicate a social desirability response, whereby mothers wished to avoid giving the impression that they were less conscientious in the care of their babies" (Richter 1994:23). Although most mothers in the Richter study thought that their babies were crying less than normal, 66 out of the 100 reported having given their infant medication for crying. The medicines involved were Dutch medicines such as *Haartemensis* or *Stuipdruppels*, and over-the-counter medicines such as *Muti Wenyoni*, Panado Syrup, Woodward's Gripe Water or Baby's Own Tummy Tablets, while some mothers burnt *Doepa* or *Mphepa* (Richter 1994:23).

My research confirms these findings about the use of medicines to soothe crying infants. The subject will be discussed in more detail in Chapter 8 and 9.

### **Umbilical Cord**

The baby's umbilical cord is carefully cut after birth and the area around the cord treated with "medicine" ranging from herbs to powdered mouse droppings. Soweto women still treat the umbilical cord with medicine with the difference that the medicine is no longer herbal but usually one or more Dutch medicines (Chapter 8).

### **Meconium**

The meconium in the baby's stomach is often removed by way of an enema which contains herbs (Jali 1950:17). For the Zulu baby the roots of the *umThambane* plant (*Stephania hermadoefolia*) are used (Krige 1950:66). A Pondo baby receives an "infusion of *isihlambezo somntana* (*irwexane*, *Rubia cordifolia*), a different plant from the mother's *isihlambezo* (is used) 'to purge the stomach of what it has been living on before birth'" (Hunter 1964:152). Again, Pijper (1919:32) describes a similar treatment for Boer babies

in the early 20<sup>th</sup> century: "Elk Transvalertje krijgt dadelik een 'purgatie', een mengsel van casterolie, rhabarber, en nog enkele andere, mij niet bekende ingriendingen"<sup>10</sup>.

### First Bath

Babies are carefully washed in water after birth. The water, warm for some groups and cool for others, is often treated with medicine. The Pondo baby of the 1930s was washed in warm water and then given soot from the hut's roof in water to see if it can swallow (Hunter 1964:152), while the Pedi child of the 1960s was washed in cool water containing "certain healing and purifying medicines" (Mönnig 1967:100). Krige (1950:65) describes how Zulu mothers sometimes use the *uMalali* plant to wash the baby. They do this "to make it a quiet child, not given to crying, for the water is always medicated with some *intelezi* (medicine)". This water must then be discarded so that no witches can use it to harm the baby.

Babies are not always washed with water but sometimes rubbed with fat. Ashton (1952:28) mentions that Sotho babies are sometimes washed with "a special lotion, and rubbed with ointment", while Krige (1950:66) tells us that both the Zulu baby and mother are smeared with fat. An interesting aside about Boer babies at the turn of the century by Pijper (1919:33) is that they were not washed during the first four weeks but wiped off with *soetolie*<sup>11</sup>, a Dutch medicine.

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<sup>10</sup>Every Transvaal baby receives a purgative which is a mixture of castor oil, rhubarb, and other ingredients not known to me,

<sup>11</sup>Sweet oil.



## First Feeding

Many ethnographers mention that babies are given substances other than breastmilk soon after birth. These substances usually include soft porridge, gruel and/or a medicinal infusion which may be "force fed" to the baby (Mönnig 1967:101; Van der Vliet 1974:214). Almost immediately after birth, even before being breast fed, the Sotho baby is given a little porridge made of uncooked sorghum (*mabele*) (Ashton 1952:30). This was done to see if the child was a human, a monster, or the child of a familiar (*thokolosi*). By 1952 it was a seldom used ritual (Ashton 1952:30).

Again it is interesting that Boer babies in the Transvaal received tea with sugar water during the first two days and only then breastmilk whenever the child cried (Pijper 1919:33).

Richter's (1994:16) Soweto study found that the 56% of Soweto mothers began to give water to babies within the first five days of life and by the tenth day 68% of the babies were receiving water. The water is mostly cooled down boiled water often with sugar added, or salt and sugar and in some cases herbs.

## Isolation

The mother and baby are secluded for a period that ranges from five to ten days to protect the baby from contact with harmful elements and keep the unclean mother away from the community (Ashton 1952:29-30; Hellmann 1948:59; Krige 1950:68; Van der Vliet 1974:214). The isolation usually lasts until the cord drops off. The father of the child and men in general are not allowed near the mother and child during the period of seclusion "lest they harm the child or are themselves polluted by the impurities which surround the childbirth" (Van der Vliet 1974:214). Hellmann describes a similar situation for the people

of Rooiyard and added that only young premenstrual girls, postmenopausal women, and close female friends who were not menstruating or had not had sex the previous night were allowed as visitors. "If these rules are disregarded it is believed that the child's genitals, navel or fontanelle will be affected" (Hellmann 1948:59).

In 1994, Richter found that 89 of the 100 mothers interviewed thought that babies should be kept indoors for a period after birth. The suggested period varied from one to more than 60 days. In contrast to what women did in the past the present study indicates a rather lengthy post-partum period of relative isolation for the baby. This confirms a study by Bergh in 1986 who indicated that Pedi mothers and babies are kept inside for periods that vary from 10 to 90 days (Richter 1994:25).

**6 Length of Time Babies Should Be Kept Indoors**  
(n=89)

1 to 10 days	16
11 to 30 days	37
30 to 60 days	19
60+ days	27

Source: Richter 1994:26

Mothers suggest a variety of reasons for keeping the child indoors: to prevent the baby coming in contact with bad things (including bad spirits) in the air (36%); because the child is weak and vulnerable (28%); because the baby's cord is not healed (15%); because it is common practice (15%); and other reason such as avoiding the sun or wind (Richter 1994:25).

### Protection and Strengthening after Birth

Because the first few months of a baby's life are viewed as critical, the child is very weak, and needs to be specifically protected by medicines or amulets against childhood dangers (Ashton 1952:30; Mönning 1967:102; Van der Vliet 1974:214 & 217). Most ethnic groups have rituals aimed at strengthening and protecting babies. For example, the Venda, Pedi and Zulu, make many little cuts on different parts of the child's body and rub medicine into them, while Xhosa, Bomvana, Bhaca, Mpondo, and South Sotho hold the baby in the smoke of a fire of burning medicines (Van der Vliet 1974:214). So important is strengthening a baby that the Tsonga, for example, believe that a child cannot grow from milk alone. Junod quotes the Tsonga idiom: "*Mwana a kula hi miri*, the child grows by medicine..." (Junod 1927:48)

This is the reason why a Tsonga mother always has a reed with black powder with her. The medicines in the reed protects her baby against dangers and a calabash with medicated water which she also carries protects her child against the two most dangerous childhood illnesses, convulsions and infantile diarrhoea. The Tsonga believe that these two illnesses are "caused by an internal snake or worm (*nyoka*) and, unless checked by the routine use of medicine, will cause the child's death" (Van der Vliet 1974:217).

African mothers are very scared of all the potential dangers to their small babies. Krige (1950:66) says about Zulu babies that

shortly after birth every baby is held in the smoke of burning animal charms, comprising a small particle of every possible animal of ill-luck. This is supposed to counteract all *izinyamazane* diseases which the child may have contracted while in the womb, through its mother having walked over tracks of harmful animals, or that may be brought in by people who come to visit the baby with bad medicine of this nature. To make sure that the strengthening medicine will be effective, some is given to the child to drink with its food, while the ashes of the burnt animal charms may be put as medicine in a necklace for the child (Krige 1950:66).

Bryant (1949:614-615) describes a Zulu baby smoking process (*ukuTunqisela*) in his Zulu ethnography. He says that the mother of a child picks up all suspicious rubbish (*umKondo*), burns it in a fire and holds her baby over the smoke. In that way she protects her baby from "poisonous smells" by making it immune to poisons. He also comments on the dangers of "underfoot evils or path-poisons" such as certain animal poisons (*iziNyamazane*) whose "smell" a mother can pick up and pass on to her baby. It is also necessary "to smoke" the baby against *iziNyamazane*.

By a timely inhalation of these harmful 'emanations' (*iPunga*) sinking of the fontanelle, bladder trouble and diverse other ailments which might affect the child either now or in the future, would be quashed in the bud (Bryant 1949:615).

Schapera remarks that the Tswana do a protection ritual in the traditional way which

normally consists of burning certain roots, in whose smoke the baby and its mother are both made to bathe. The ashes are then ground, and some of the powder is given to the baby to eat. The rest is mixed with fat, and used as an ointment with which its ears, nostrils, and fontanelles, are regularly smeared (Schapera 1941:235).

However, according to Sharpera, at that time the Tswana often also doctor the baby after birth to ward off convulsions, with patent medicines that people buy at the store. Unfortunately he does not identify the medicines.

Not only are babies doctored for protection after birth but they are also doctored after the period of seclusion. Mönig (1967:102), writing about the Pedi, says that at the end of the period of seclusion the African doctor is called to prepare the child "*go thusa ngwana*" (literally to help the child). This ritual consists of two things: firstly "*go papatela*" (to smooth the head of the child) where the hair is shaved off to prepare the child to look

like members of the tribe in terms of hairstyle, and secondly "*go tisetsa*" (to strengthen) to prepare the child against witchcraft since after the period of seclusion the baby will no longer be protected by the "*lepheko*" which guarded the hut.

The protective medicine *tshidi* is burnt in a broken potsherd over a fire, while the child is held in the smoke. The witch doctor then makes small incisions on all the major joints of the child, the ankles, the knees, the hips, the neck, the shoulders, the elbows and the wrists as well as on the temples. In each of these incisions he rubs a little of the powdered medicine (Mönnig 1967:102).

Although the details have changed Richter (1994:25) found in her Soweto study that the majority of mothers indicated that the two most important goals for a mother's efforts around her baby should be to make the baby "strong and healthy" and "prevent the child from contracting illness". One of the ways to do this is to perform certain cultural and religious rituals. Forty nine percent of the women told her that there were specific cultural and religious rituals that very young babies should undergo, although almost half of the women could not give details about what these rituals should be.

Nine mothers wanted their children to undergo a ceremonial acceptance into one or another church; 10 had placed amulets of one kind or another on their infants, 4 children had participated in ceremonies in which a goat or sheep had been slaughtered<sup>12</sup>, and the remainder mentioned scarification, passing an infant through smoke, and various kinds of oral ceremonies (Richter 1994:25).

### Daily Rituals of Strengthening

To ensure the continuing health and well-being of the child there are also daily rituals that need to be followed. The baby usually has to be bathed with medicines added

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<sup>12</sup>Zulu children are "placed under the protection of the ancestors by a sacrifice of a goat known as *imbeleko*". The first armband for the baby is from this goat. This ritual is done during the baby's first year. With this sacrifice the ancestors are thanked for the baby and asked to protect the baby (Ngubane 1977:51-52).

to the water, smeared with medicines, given medicines to drink and held in smoke from medicines.

Hunter (1964:152) wrote in 1936 about the Pondo, that the baby was washed every morning in warm water and that some herbs or a piece of skin of a goat were burned while the mother holds "the child over them passing it to and fro through the smoke". The child had to swallow some of the smoke.

Although a baby should be smoked twice a day many mothers do not do it more than once, and others omit it some days 'because they are busy' or 'because they have not got the herbs... Reasons for the ceremony (*ukuphehla* or *ukufutha*) vary. One informant says that it is to bring out the rash (*ipita*) which Pondo believe must come out if the child is to be healthy. Another says it is to make the child stop crying and sleep easily; another .. That it is to make the child grow well. ...the most usual explanation is that smoking makes the child strong (Hunter 1964:154).

In addition to bathing the baby and holding it in the smoke the mother carries a charm with a protective root round her neck. If she has been walking around, before giving the baby breastmilk she bites off a small piece of the root and spits on the baby's "forehead, throat, genitals, sacral region, and back of the neck, in the order mentioned". Then the mother squirts breastmilk on these same body parts of the child. She does this in case she "has walked across the spoor of *umuntu nemimoya* (a person with spirits, i.e. a witch or sorcerer) and contracted something that would harm her child" (Hunter 1964:156).

Krige describes an elaborate ritual where a Zulu child is held in the smoke ascending from scented wood and medicines containing pieces of wild animal flesh.

This smoking had to be performed daily with closed doors for several weeks while the mother sang special chants. The odor of these medicines is supposed to repel wizards who seek to injure small babies, and is said to cling to the baby for about eight months. Hence the ceremony is repeated every eight months until the second teeth appear, after which the child is thought to be able to take care of itself. Should the child grow up to enjoy sound health it is always said, 'the animal charms were rightly combined' (Krige 1950:67).

Hellmann describes the daily rituals performed by Zulu mothers in Rooiyard. The aim was to ensure their babies' safety against illnesses such as the dreaded "Basotho sickness".

*Kafaza*, a root, is ground and put into water, with which the baby must be washed every morning. A herb, *dupa*, is sewn into a braid and put around his neck. The mother burns *ndungula* in the morning and holds her child over the smoke so that the sickness may be kept far from her child (Hellmann 1948:64).

These mothers also gave their babies enemas every week or two to clean the child's stomach from the "green things" and the snake that was caused by the deadly "breath of the Sotho". If the woman goes out with her child she first "burns *isipepeto*"<sup>13</sup> to protect him against the breath of the Sotho" (Hellmann 1948:65).

### Summary

There are four broad sets of theories used by Africans in South Africa to explain the "condition of being human". These are beliefs about a supreme being, ancestors, witches and pollution. Any of the four agents that can cause serious illness under certain

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<sup>13</sup>Apparently referring to *Imphepho* (Chapter 8).

conditions. Illnesses connected to any of these agents are thought of as "diseases of the African peoples".

In this context the life of a new born African baby is considered to be fragile by its parents, as well as the community. In fact, the baby will stay vulnerable for many months after birth. To ensure the child's survival and continued health, parents, especially the baby's mother, need to take special steps and perform certain rituals. These steps, which begin while the woman is pregnant, include avoidance of potentially dangerous situations, the performance of certain rituals immediately after the birth, as well as the maintenance of specific daily or weekly rituals.



## CHAPTER 8 *DIBOTLOLO TSA BANA*<sup>1</sup>: DUTCH MEDICINES FOR SOWETO INFANTS

### Introduction

Although Dutch medicines were initially mainly used by pioneers and later Afrikaans speaking people, they became popular with many other South Africans during the 20<sup>th</sup> century. Unfortunately it was not possible to find any marketing or sales figures broken down by geographical area or ethnic group that could help with trying to understand when sales of Dutch medicines expanded. It is unclear when black South Africans really started to use Dutch medicines for infants but it must have been earlier this century. There was close contact between Afrikaners and different groups of Africans on the *platteland*, in towns and on farms where illnesses were often treated with Dutch medicines. Africans were also familiar with patent medicines advertised and marketed in newspapers (Government Report 1936:10-11).

We got very little proof on Dutch medicine use by Africans from those sources. Anthropologists seldom reported on any patent medicine use in their ethnographies and articles. However, there are a few exceptions. Hellmann (1948) for example, tells us that the herb "Dupa" was used in Rooiyard. At the time she did not seem to realise that it is a Dutch medicine. Brindley (1976:22), writing about the Western Coloured Township says

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<sup>1</sup> "The bottles for babies"

that Lennon's Dutch medicines are used for a variety of infant problems. For example, if a child has trouble sleeping *Rooilavente*<sup>2</sup> is mixed with milk. Without elaborating Du Toit mentions the use of Dutch medicines among South African whites (1966 and 1974), Indian women (1990) and recently among Coloureds (1998). Jopie Koen (1986) reports on the use of *Stuipdruppels* for infants by Basotho women in the Frankfort district (see *Stuipdruppels* in this chapter).

In 1982 while working for the Department of Health in the eastern part of the Free State Province, and again in 1993 while helping with a study on early infant care practices in Soweto I noticed that a large number of African mothers used over-the-counter medicines (especially *Muti Wenyoni* and different kinds of Dutch Medicines) for their infants. African mothers mostly used these medicines as protection and prophylaxes against serious infant illnesses and to soothe restless babies. It was clear that the medicines were not used as they were supposed to be used. Different Dutch medicines were for example mixed and given to the child.

In this chapter I report on my investigation of the use of Dutch medicines for infants in Soweto. I describe the different medicines used, how and why they are used, how often they are given to the infant and how much is given. I also discuss the women's knowledge of side effects, her sources of such knowledge and the places where she obtains the medicine.

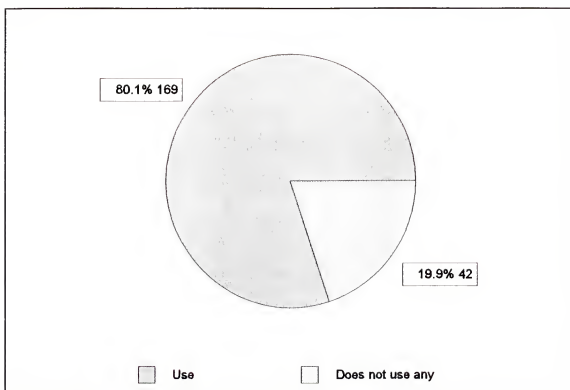
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<sup>2</sup> According to the Lennon's 1985 package insert *Rooilavental* is "effective in the treatment of winds, indigestion and associated stomach aches. The drug is a carminative and is believed to exert some antispasmodic action on the stomach and intestinal muscles. Children should receive 10 drops (0.5 ml) in a little sweetened water, when necessary".

### Types of Dutch Medicines Used in Soweto

Eight out of ten (a total of 169) women in the sample used either one Dutch medicine, or mixed from two to ten different types of Dutch medicines for their infant (see Figure 5). Ten of the 169 women either used an additional medicine or medicine mix. For example, *Stuipdruppels* (to protect the child against being frightened) may be mixed with *Haarlemensis* (to protect the child from inhaling bad spirits) and one or both may be mixed with *Behoedmiddel* for diarrhea.

The total number of different kinds of Dutch medicines used was 19 (Table 7).



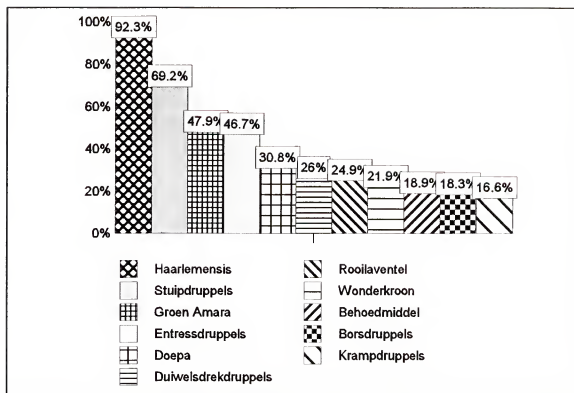
5 Percentage of the Soweto Sample That Use One Or More Dutch Medicines (n=211)

# 7 Nineteen Different Types of Dutch Medicines Are Used by the Soweto Sample (n=169)

NAME OF DUTCH MEDICINE	NUMBER OF PEOPLE USING EACH TYPE
<i>Balsem-Kopiva</i>	4
<i>Behoedmiddel vir Kinders</i>	32
<i>Borsdruppels</i>	31
<i>Duiwelsdrek</i>	1
<i>Duiwelsdrekdruppels</i>	44
<i>Doepa</i>	52
<i>Entressdruppels</i>	79
<i>Essens of Groen Amara</i>	81
<i>Haarlemensis/Haarlemmerolie</i>	156
<i>Jamaikagemmer</i>	3
<i>Krampdruppels</i>	28
<i>Paragoriese Elikser</i>	3
<i>Rooilaventel</i>	42
<i>Staaldruppels</i>	2
<i>Stuipdruppels</i>	117
<i>Turlington</i>	1
<i>Versterkdruppels</i>	7
<i>Witdulsies</i>	3
<i>Wonderkroon</i>	37

From this table we can see that some medicines are used much more than others.

Figure 6 represents the 11 most used medicines. Four of the medicines are clearly more popular than the others (see Figure 6). They are *Haarlemensis* (92.3%), *Stuipdruppels* (69.2%) , *Groen Amara* (47.9%), and *Entressdruppels* (46.7%).



6 Percentages of the 11 Most Popular Types of Dutch Medicines Used by the Soweto Sample (n=169)

### *Haarlemensis*<sup>3</sup>

*Haarlemensis* is the medicine most often used by the Soweto women. Women told me they like *Haarlemensis* because it is the only Dutch medicine that is oily and sticky and "sticks" better to the baby than the other medicines. Therefore it has a long lasting effect and protects the child better. It is also considered a powerful medicine. One mother explained:

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<sup>3</sup>The package insert (1985) describes *Haarlemensis* as a treatment for kidney and bladder complaints. It contains Balsam Sulphuris Base, Arachis Oil, Tar, Turpentine Oil and its pharmacological classification is under the laxatives. The pharmacological action is described as: "the precipitated sulphur in the balsam sulphuris base has a mild laxative action and the tar has an expectorant action" (Appendix C).

People told me I should use *Haarlemensis* against the spirits of the baloi because I did not use it with my first baby and that's why he died.

*Haarlemensis*, also known as *Haarlemmer Olie*, *Oleum Harlammense*<sup>4</sup>, *Harmansdrup*<sup>5</sup> is a very old Dutch medicine (and probably the only one really from The Netherlands). According to Bakker (1928:27-28) "*Haarlemmer olie was in de vorige eeuw het kwakzalversmiddel bij uitnemendheid*" (During the previous century Haarlemmer olie was used as a quack-remedy par excellence). It was used for all kinds of illnesses and was also used as an abortifacient. The *Nederlandsch Tijdschrift voor Geneeskunde* (1857:177) also mentions *Haarlemmer-olie* as one of the *volksmiddelen* (folk medicines) misused to bring about abortions.

The earliest reference to the use of *Haarlemensis* in South Africa is by the Voortrekker Trichardt in his diary where he describes the treatment for the trekker Pieta, injured under a wagon wheel. Pieta lived to tell the tale after receiving in "rapid succession chalk, weak vinegar, turpentine (*termentijn*), *Haarlemmer olie*, again turpentine and finally had his whole body rubbed with fat (Burrows 1958:194).

*Haarlemensis* is described in the Dutch medicines pamphlets. The 1840 and 1852 pamphlets and the 1890 Lennon's Domestic Remedies pamphlet describes Haarlemmer

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<sup>4</sup>In the 1852 pamphlet *Kort Berigt over de Krachten en Het Gebruik van de Voornaamste Huismiddelen; express geschreven voor buitenlieden, welke door woonplaats en andere omstandigheden belet zijn bij ieder twijfelachtig geval geneeskundig advies te nemen* (Short report on the strengths and uses of the most important home remedies, especially written for rural people who are prevented from getting medical advice because of their location or other circumstances).

<sup>5</sup>A well known Afrikaans idiom describes someone who is very slow as *Haarmansdrup*. This probably refers to the sticky consistency of *Haarlemensis*.

Olie as a "remedy known for many years and discovered in Haarlem and of such great power that a description of it would too much enlarge this pamphlet; for this reason a description of its virtues and complete directions for use are wrapped round every bottle". Unfortunately I could not find any of these "wraps". From the 1960s to 1990s the product is advertised as *Haarlemensis* in Lennon's Dutch Medicine Handbook: Home Remedies. "This old and established remedy, discovered and founded in Haarlem in the year 1672, has proved to be very effective for minor kidney and bladder complaints and difficulty passing urine. Fifteen drops should be taken in milk at bed-time". By 1997 the Lennon's Natural Medicines' pamphlet encourages the use of *Haarlemensis*: "Even minor kidney or bladder complaints can be highly uncomfortable. *Haarlemensis* relieves painful cramping whilst working hard to restore your body's natural balance".

### ***Stuipdruppels*<sup>6</sup>**

*Stuipdruppels* the second most popular medicine used by the Soweto women, is not as old as *Haarlemensis* but was already well-known in the 1800's. It was advertised in the 1869 Juritz's *Kort Berigt for stuipe*<sup>7</sup> (fits) and 1884 Lennon's Catalogue. From the

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<sup>6</sup>The package insert describes the indications for the use of *Stuipdruppels* flatulence, gripes and colic. The ingredients are: Tincture Valerian, Cassia Oil, Nutmeg Oil, Rosemary Oil, Spike Lavender Oil, Tincture of Asafoetida, Solvent Ether, and Ethanol (100%). It is classified under Gastro-intestinal Antispasmodics and Cholinolytics and acts as a carminative (Appendix C).

<sup>7</sup>A 1996 circular (12/96) by the South African Medicines Control Council (MCC) lists *Stuipdruppels* as one of the misleading and inappropriate names of medicines. It states that "the names and phrases on the attached list are regarded as being misleading and Council is of the opinion that these names should no longer be permitted as proprietary names for medicines" Companies are given time to submit their comments after which the MCC will make a final decision and the "Industry will be granted 90 days in which to change the proprietary names of the relevant medicines". A second circular (7/97) with additional names was sent out in 1997 and according to the MCC the final decision will be

1960s to the 1990s the Lennon's Dutch Medicine Handbooks describes *Stuipdruppels* as: "These drops act as a sedative for the nerves in cases of nervousness, restlessness and sleeplessness. They are useful also for pains and cramps in the bowels and stomach". The 1997 Lennon's Natural Medicines' pamphlet tells us that: "these drops act as a sedative and are useful in calming nervousness and restlessness as well as inducing sleep (Not to be taken by children under 2 years). For nervous disorders take half a teaspoonful, 3 or 4 times a day and especially at night. For pains and cramps take half a teaspoonful every half-hour until relieved".

I found only two references to the use of *Stuipdruppels* by anthropologists. The one is by Brindley who writes: "Young (coloured) infants are kept healthy by rubbing one drop of warmed *Stuipdruppels* or *Versterkdruppels* over the child's body" (Brindley 1976:22). And the other is a fairly detailed discussion in Jopie Koen's masters thesis on the South Sotho of Frankfort district which give us an indication of the nature and use of *seteipi* (1986:80-82).

Koen describes in detail the use of *Stuipdruppels (seteipi)* for protection for a baby who has to temporarily leave the room where mother and child are isolated. Although her informants could not explain the nature and mechanisms of *seteipi*, they nevertheless indicated that it plays a very important role in sustaining the health of infants and young children.

Koen suggests that the word *seteipi* is a modification or transformation of the Afrikaans word *stuipe* (fits). She says that the *Stuipdruppels* available in the Free State has the word *seteipi* printed on it suggesting that the medicine is for the illness *stuipe* (fits).

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in early 1998.



*Seteipi* can be used for good and for evil because it can be used to protect children but can also be used to harm them. She refers to Ashton's (1952:289) description of *seteipi*: "...*seteipi* is normally used to protect infants, but in the hands of a sorcerer and applied with malevolent intent, i.e. smeared on a stone and left near the child, it will do it serious harm". In fact, Ashton makes an earlier references to *seteipi* (or *setipi*). In 1943 he writes:

"Sorcerers have two kinds of medicine. Some are capable of only doing harm, others are special medicine, like *setipi*, *mohato* and *mohlala*, which are normally used for benevolent ends but become noxious when used with malevolent intent. *Mohato*, for instance is normally used by smearing an infant's head to protect it from sorcery and from harm which might come to it through crossing unfrequented paths. But in the hands of a sorcerer it can kill or maim a child. Its effect depends entirely upon the purpose to which it is put" (Ashton 1943:5).

Elsewhere in his 1952 study Ashton writes about the new mother that is not allowed at first to go far from her hut especially if she has to cross water or busy footpaths. The main reason for this is to:

"avoid contact with a dangerous medicine called *seteipi*, used by malevolent people, chiefly men. The child can be harmed by passing near where the *seteipi* has been dropped or by crossing a path taken by someone carrying this medicine. If the child has to go out before it has 'set', it can be protected by a special medicine such as *mothaleho* or *mohato*, which is smeared on the fontanelle or the nape of the neck, and from ear to ear (Ashton 1952:30).

According to Koen's informants it is only infants and young children that could be harmed by *seteipi*. *Seteipi* could cause illness if the child accidentally comes in contact with it or could be used intentionally to cause an illness to a child by "sprinkling" water mixed with *seteipi* near the child's home. *Seteipi* is reportedly very strong - when people who bathed in *seteipi* water come too close to a child, the child could become ill. A mother who moved past a place where *seteipi* was put could pass it on to her child through breast-feeding. Ashton (1952:30) says that "...the child can be harmed by passing near where

the *seteipi* has been dropped or by crossing a path taken by someone carrying the medicine”.

There are two kinds of *seteipi* reported by Koen's Free State Sotho informants: “Small” *seteipi* and “big” *seteipi*. Small *seteipi* is the one well-known as *Stuipdruppels* available from stores and pharmacies, while the informants who know about big *seteipi* were confused about what it really was - some thought it to be *Duiwelsdrek*<sup>8</sup>. Big *seteipi* is responsible for causing “fits” in children, while small *seteipi* is used for protection against fits although it could also cause illness but never as serious as those caused by big *seteipi* (Koen 1986:81). *Seteipi* is used as protection by adding a few drops to the child's bath water or giving the child a little bit with breastmilk. Children are vulnerable to the negative influence of *seteipi* until about four years of age or until the fontanelle has closed (Koen 1986:81). There is no evidence of this distinction in Soweto.

### ***Essens Amara* or *Groen Amara*<sup>9</sup>**

*Groen Amara* is the Dutch medicine which continued for the longest time in South Africa. *Essentia Amara* appears in the Von Madai 1836 Halle medicine pamphlet, but it can

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<sup>8</sup>Asafoetida “is an oleo-gum-resin obtained by incision from the living rhizome and root of *Ferula foetida* Regel, *F. Rubricaulis* Boiss., and other species of *Ferula* (Fam. Umbelliferae), plants about 3 m in height. The drug is collected in Iran, Pakistan and Afghanistan” (Evans 1989:475). It was probably introduced from the East by the Arabian physicians and was used in Europe during the Middle Ages (Evans 1989:475).

<sup>9</sup>According to the package insert (1985) *Groen Amara* is composed of the alcoholic extractives of Herb Cardui Benedict and Quassia, and contains Ethanol (100%). It is classified as a digestant and its pharmacological action is described as a stomachic bitter. *Essens Amara* or *Groen Amara* is described as “an effective tonic which improves appetite”. *Groen Amara* is also a plant (*Vernonia oligocephala*) used in the folk pharmacopoeia of South Africa.

be safely assumed that it was already present in the 1741 edition<sup>10</sup>. According to the 1836 pamphlet it was actually a medicine against scurvy, but the pamphlet lists 8 additional reasons for using *Essentia Amara*: constipation, festering wounds, flatulence, apoplexy, stomach ache, fever, colds or coughing, and bleeding gums. The 1840, 1852, 1856 pamphlets got rid of the Latin name, and list the medicine as one of their 34 *Voornaamste Huismiddelen* (most important home remedies) and call it *Essentia Amara* or *Bitter Druppels*. It is summarized in the Von Madai pamphlet:

*De groene Essentia Amara bestaat uit bittere, oplossende, de scheurbuik verdrijvende, de zenuwen sterkende en balsemachtige kruiden; dezelve kan 3 tot 4 reizen's daags worden gebruikt; waarbij de Pillulae Polychrestae 1 of 2 maal des weeks kunnen ingenomen worden, hetwelk zoo veel noodiger is, wanneer de zieken over verstopping van't ligchaam klagen, en als te gelijk eenige hitte mogt bijkomen, is het noodzakelijk dezelve met een dosis Bezoard Poeder te gebruiken. De Essentia Amara wordt gebruikt bij verzwakte maag, kolijk, buikpyn, tegen winden, bij koortsen, in slijmige zieken, bij vochtige zweeren en tegen de gebreken van het tandvleesch (Kort Berigt 1852).*

(The green *Essentia Amara* consists of bitter, dissolved, balmy herbs which remove scurvy and strengthen the nerves. It may be taken 3 or 4 times a day, using at the same time *Polychrest Pills* once or twice a week, which is especially necessary when the patients complain of costiveness of the bowels, and should the temperature be rather high it will be necessary to use them with a dose of *Bezoard Power*. The *Essentia Amara* is used for weak digestion, colic, pain in the stomach, flatulence, belching, apoplexy, over-eating, fever, in slimy diseases, for open sores, and for affections of the gums).

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<sup>10</sup>The reprint of the introduction (*Verdere Advertentie*) to the 1776 third edition, in the fourth edition, states that the pamphlet is similar to the first edition in 1741 except for spelling changes and a few additional explanations: "In deelen derden Druk zyn niet dan eenige drukfouten, en tot meerdere duidelykheid, enkelde, dog weinige Woorden verbeterd, blyvende oorigens alles in dezelfde order en geschiktheid, gelyk voorheen, zo wel ten opzichte van het Gebruik, Deugd en Kracht deezer Weeshuys-medicamenten, als ook de prysen..." (Von Madai 1836).

The Von Madai pamphlet summaries continued with the ca1890 and ca1900 Lennon's pamphlets - now also available in English<sup>11</sup>. This description remains almost the same for more than 200 years. The 1951 Heynes Mathew pamphlet, now in Afrikaans instead of Dutch, follows the descriptions from the 18<sup>th</sup> and 19<sup>th</sup> centuries:

Die Essentia Amara bestaan uit bitter, oplossende, skeurbuikverdrywende, senuwee-versterkende en balsemagtige kruie; dit kan drie of vier maal per dag gebruik word (saam met Polychrest-pille een of twee maal per week, wat baie nodig is as die sieke oor verstopping van die liggaam kla); en as die sieke terselfdertyd koorsig is, is dit noodsaaklik om dit saam met 'n dosis Besoarpoeier te gebruik. Die Essentia amara word gebruik by Verswakte Maag, by koorsigheid, by Vogtige Swere en teen Gebreke van die Tandvleis (Heynes Mathew 1951:11).

A change occurs in the English description of the 1951 Heynes Mathew pamphlet. The English descriptions differs significantly from the Afrikaans description and has much more in common with the descriptions from the 1960s onwards.

"This 'essens' is prepared from a bitter balm-herb, which is excellent as a Nerve and Stomach Tonic. In Dyspepsia and Loss of Appetite it is found very useful; it is valuable in breaking up Colds, for stimulating the Menstruation when deranged by a cold, for Colic, Wind<sup>12</sup>, Pain in the Bowels, Vomiting etc." (Heynes Mathew 1951:10).

"This is an excellent and valuable tonic preparation which improves the appetite and promotes a feeling of well-being in those people who are run-down and suffer from lack of energy. If there is any constipation, then Poligrispille should be taken at bed-time" (Lennons' ca1960-1990).

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<sup>11</sup>Green Essentia Amara consists of bitter, dissolved, balmy herbs which remove scurvy and strengthen the nerves. It may be taken 3 to 4 times a day, using at the same time the Polychrest Pills once or twice a week, which is especially necessary when patients complain of costiveness of the bowels, and should the temperature be rather high it is necessary to use them with a dose of Bezoard Powder. The Essentia Amara is used for weak digestion, colic, pain in the stomach, flatulence, belching, apoplexy, over-eating, fever, in slimy diseases, for open sores, and for affections of the gums (Lennon ca1891).

<sup>12</sup>Gas

"This highly effective tonic is a natural appetite stimulant that may safely be used by the sick or elderly, or anyone whose appetite needs a boost" (Lennon's 1997).

There are no anthropological descriptions of the use of *Groen Amara* except for that of Brindley (1976:22) who wrote that *Groen Amara* is used for stomach-aches of coloured infants.

### *Entressdruppels*<sup>13</sup>

*Entressdruppels* seems to be a South African invention according to W. Froembling a pharmaceutical chemist in Cape Town. He writes that *Entress druppels* is "named after a barber and quack who lived in the first half of the last century in Cape Town" (1932:121).

In 1932 *Entressdruppels* was made up of oil of lavender and rosemary, cinnamon bark and nutmeg, coloured with red sandalwood, asafoetida, valerian, *dassiepis*<sup>14</sup>, opium ("the morphinum content being considerably less than one in a thousand") and a drop of ether.

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<sup>13</sup> The 1985 Lennon's package insert describes the content of *Entressdruppels* as opium tincture, valerian tincture, compound lavender tincture, asafoetida tincture, and ethanol (100%). Its pharmacological classification is: central nervous system depressants: sedatives, hypnotics. The pharmacological action describes the volatile principles of valerian, lavender and asafoetida which exert a carminative action which relieves winds and stomach pains while the analgesic property of opium soothes and relaxes the intestinal muscles. Valerian has been used for nervous conditions, the calming effect of which is enhanced by the opium tincture which promotes restful sleep. *Entressdruppels* is indicated for the relief of stomach pains and winds, nervous conditions and sleeplessness.

<sup>14</sup> *Dassiepis* is also known as *Hyaecum* and is the dried up excreta of the *Hyrax capensis* (*dassie*) that can be found on the rocks and cave bottoms where they live (Froembling 1932:121). I recently noticed that street traders of medicinal plants in the Eastern Cape Province (Graaff-Reinet) and Johannesburg still sell *dassiepis*. See also Du Toit (1998).

Froembling (1932:121) describes it as a popular cure-all for the old as well as the young. He says: "The offensive smell of asafoetida, sufficient to drive hares and deer from cornfields, will react on the olfactory nerves of certain persons in such a way that it was in use nearly fifty years ago as a remedy for nervous disorders, hysterics and similar complaints", and that the "strength of '*Entress droppels*' is assessed by the experts (!) in accordance with the amount of stench emanating from it and the density of the red colour".

*Entressdruppels* appears for the first time in the 1869 Juritz pamphlet as *Endress Droppels* and is advertised as the original prescription popularly used for adults and children for cramps and *stuipe* (fits). He also advertises *Endress Kruiden* in the same pamphlet. The 1884 B.G. Lennon & Co. catalogue of Drugs, Chemicals, Patent, Proprietary, and Dutch Medicines etc. lists *Entress Droppels* for sale but no mention is made of it in the Lennon's ca1891 and ca1900 pamphlets.

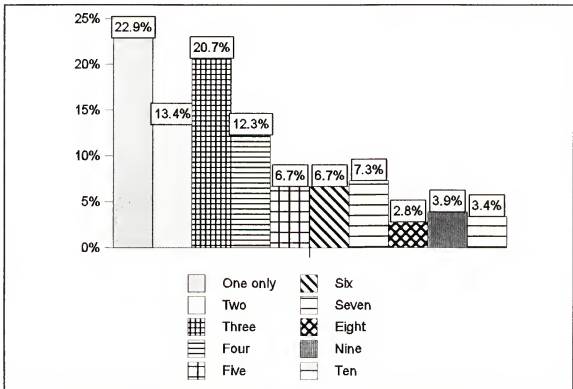
Heynes Mathew's pamphlet (1951) calls *Endressdruppels* a "wonderful and extraordinary remedy (that) may be taken for any and all pains arising from Stomach Weakness", the Lennon's pamphlets from ca1960 to 1990 suggest that:

These drops have a decided calming effect and soothing effect in cases of nervousness, nerve disorders and sleeplessness. 20-30 drops should be taken 4 or 5 times a day and especially at night. They also bring relief in stomach pains and in cases of wind in the stomach and bowels. For this purpose take 20-30 drops every half an hour until relieved (Lennon ca1960; Lennon ca1990).

In 1997 the Lennon's Natural Medicines pamphlet tells us that "these drops have a soothing and calming effect, and promote a good night's sleep. Use to treat stress, nervous disorders or insomnia (no children under 2 years). May also be applied directly to cuts or minor wounds to stop bleeding".

### Mixing and Combining Dutch Medicines in Soweto

Most women (81.7%) using Dutch medicines combine two or more medicines, while 22.9% used one medicine only (see Figure 7). The medicines that are most commonly used separately are *Behoedmiddel*, *Entressdruppels*, *Groen Amara*, *Haartemensis* and *Stuipdruppels*. There are different reasons why women do not mix them. *Behoedmiddel* is used for diarrhea, *Groen Amara* is sometimes specifically used to clean and heal the baby's cord from the inside, while *Haartemensis*, *Entressdruppels*, and *Stuipdruppels* are used by themselves because of their strength. For example a woman said: "I never give my baby *Entressdruppels* to drink as I think it is too strong". But these medicines can also be mixed. The number of medicines most often mixed are *Haartemensis*, *Stuipdruppels* and *Groen Amara* or *Entressdruppels*.



7 Number of Dutch Medicines Used At a Time (Excluding Doepa) (n=179)

Combining or mixing Dutch medicines has a long tradition. Dutch medicine user pamphlets often encouraged people to combine medicines. For example, the 1836 4<sup>th</sup> edition of Von Madai pamphlet on Halle medicines, tells people that they could use *Essentia amara* (later *Groen Amara*), in combination with *Essentia dulcisto* to strengthen the action of the *Essentia amara*. "By aldien men de werking dezer Essens wil vergrooten of sterker maken, dan vermengt men ze met de Essentia dulcis..."<sup>15</sup> (Von Madai 1836:28). More than a 100 years later, in 1951, the Heynes Mathew pamphlet still directs users about *Groen Amara*: "for a more powerful remedy, 40 drops of *Groen-Amara*, together with 15 drops of *Essens Dulcis*, according to age, may be taken" (Anon 1951:12).

Mixing medicines is also encouraged. A 1852 pamphlet on Dutch medicines, tells us that Sennablare, a purgative, could be used by:

Putting two tablespoons Epsom Zout and two teaspoons Sennablare with a little bit of crushed ginger in a pot. Add three cups of boiling water and leave for ½ an hour. Pour through a clean cloth and add 60 drops of Amara. Use a wine glass full, any time, until it works well (Kort Berigt over de Krachten 1852:22).

Also a Lennon's pamphlet, still in use in the 1980s, suggests that Paragoriese-elikser be "used for chills and pains in the stomach and is especially good for this purpose if mixed with one teaspoonful of Hoffmansdruppels" (Lennon ca1970:15). Thus, mixing and combining<sup>16</sup> Dutch medicines got an "official" sanction from the manufacturers over the

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<sup>15</sup>If you want to strengthen the impact of this essence, you should mix it with *Essentia dulcis*.

<sup>16</sup>For rheumatism: Mix 1 bottle of Levensessens, 1 bottle *Doepa* (oil), and 1 bottle *Duiwelsdrek* in equal quantities and drink 1 tablespoon of the mixture every evening (Coetzee 1965:#5951). For weak heart and thrombosis mix: 1 bottle Versterkdruppels, 1 bottle Rooilaventel, 1 bottle Balsem Kopiva, 1 bottle Bruindulsies, 1 bottle Hoffmansdruppels, 1 bottle Kaaipoitolie, a pea size piece of each *Duiwelsdrek* and *Doepa*. Take 3 drops in a spoon with water, 3 times a day (Coetzee 1965:#2311). There was also



years and people have also come up with their own mixtures as is evident in the many folk recipes for various kinds of illnesses.

It is therefore not surprising that the Soweto women mix their medicines. It is not entirely clear why people use certain combinations - three medicines versus ten medicines, *Groen Amara* versus *Entressdruppels*. Most women are handed down the "recipes" from their mothers or grandmothers or get it from friends or neighbors. Some places seem to have a "standard" number of bottles they use. For example, a pharmacist in Hazyview, Mpumalanga Province, showed me a list of 6 names on his pharmacy wall above the boxes with Dutch medicines. "Women just come to the pharmacy and ask for '6 bottle'", he told me.

Although some of the medicines are viewed as strong and potent, or even dangerous by themselves (for example *Stuipdruppels*), mixing medicines is probably done to enhance the potency and strength of the concoction. By making the medicine extra strong you could have some control over the outcome.

Women certainly have faith and trust in Dutch medicines:

"We are afraid to use African medicine because you use them and they might not be good, so with *itaip* (stuip) we protect against evil spirits". (This woman mixes *Haarlemensis*, *Stuipdruppels*, *Entressdruppels*, *Groen Amara*, *Behoedmiddel* and *Borsdruppels*).

"The child will not inhale spirits of people who use strong medicine. Since I started using *Haarlemensis* the child does not inhale like before".

"I use *Haarlemensis*, *Stuipdruppels*, *Groen Amara*, and *Rooilaventel*. The baby must always be fresh and strong and never be tired. The baby will seldom be sick because these *druppels* (drops) make her strong"

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the *deumekaargood* (mixture of medicines) for internal and external use of the Boers that I referred to in the previous chapter.

But a person has to be a believer for it to work:

"If you believe in all the things that you as a mother grow up with, then all this medication will help, but if you don't, they won't work and it will be useless to try them".

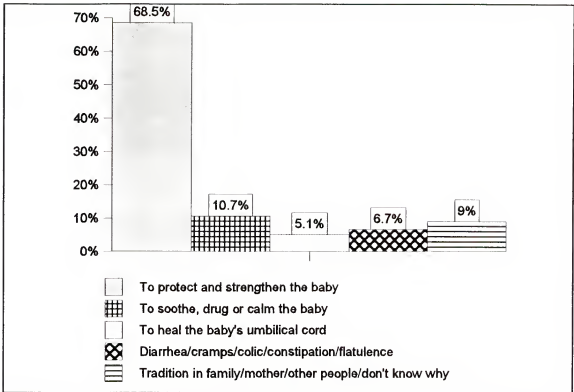
### Conditions Dutch Medicines are Used for and Why They will Help

The reasons why women use Dutch medicines can broadly be divided into five categories (Table 8).

**8 Reasons for Using Dutch Medicines (n=178)**

REASON		NUMBER OF PEOPLE
To protect and strengthen the baby against:	Being frightened by noise, the <i>baloi</i> , or being tossed in the air.	6
	Inhaling ( <i>gabo/a</i> ) bad spirits ( <i>memoya emebe</i> ), bad spirits of strong medicine ( <i>moya o mobe wa dithlare tse strong</i> ), bad spirits of the <i>baloi</i> ( <i>memoya emebe ya baloi</i> ) or the dirty spirits of Satan ( <i>imimoya ka Satan</i> )	101
	Being suppressed ( <i>gatega</i> or " <i>getrap wees</i> " <sup>17</sup> )	5
	Children's illness ( <i>malwetse a bana</i> )	10
To soothe, drug, or calm the baby		19
To heal the baby's cord		9
To stop diarrhoea, cramps, colic, constipation, or flatulence		12
Had been done by her own mother, tradition in the family, see other people doing it, does not know why		16

<sup>17</sup>Literally means "to be stomped on".



8 Reasons for Using Dutch Medicines (n=178)

### Protection and Strengthening of the Baby

The majority of women (68.5%) used Dutch medicines to protect or strengthen their babies. The four things against which mothers protect and strengthen their infants are: being frightened, "inhaling", being "suppressed", and childhood diseases.

#### Inhaling

Because infants are perceived to be very vulnerable during their first year of life most mothers protect their infants against *gabola* (inhaling evil). Among the evils which a child can inhale are *emoya emebe* (bad spirits), *moya o mobe wa dithlare tse strong* (bad spirits of strong medicine) or *memoya emebe ya baloi* (bad spirits of witches/sorcerers) and

*imimoya ka Satan* (the dirty spirits of Satan). Inhaling any of these bad spirits will lead to childhood illnesses of a particular serious nature i.e. *kokwanalinyoni* and *phuagwana/ukhakhae*<sup>18</sup> or make the baby limp or cause a stomach ache.

### Bad spirits

The bad spirits that women are referring to are usually the result of some kind of pollution for example contact with someone who had an abortion, or had sexual intercourse or was in contact with a corpse (see Chapter 6). The women described the kind of protection and the reasons for having to do it in the following terms:

"I use *Stuipdruppels*, *Haarlemensis* and *Wonderkroonessens* so that the child should not *gabole* (inhale) the bad spirits like when someone had an abortion. If you put it on the child you can take the baby anywhere and it will never *a kule* (i.e. get sick)".

"I use *Haarlemensis*. I do this so that my baby must not inhale bad spirits for example when my woman friend had gone out with boys. Because the baby is still small they will make him sick after them having had sexual intercourse".

"I use a mix of *Duiwelsdrek*, *Entressdruppels*, *Groen Amara*, *Haarlemensis*, and *Stuipdruppels*. It is for shielding the baby from bad spirits and to prevent bad spirits coming near her. When the baby does not sleep at night, may be it is because there are things that are not good in the house like bad spirits".

### Bad spirits of strong medicine

Because there are so many people (adults and children) around who have used some kind of strengthening medicines a mother cannot take enough care to protect her

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<sup>18</sup>For a more detailed discussion on *Inyoni* and *Phuana* see Chapter 9.

child from being affected by the bad spirits of strong medicine<sup>19</sup>. An unprotected baby that comes in contact with someone who has been strengthened will certainly become very ill<sup>20</sup>.

The medicine used for strengthening is in general called African medicine<sup>21</sup> and can be in herbal form or a pharmaceutical product bottled under an indigenous name. It is interesting that Dutch medicines acquired "African medicine" power and status over time and are used widely as the preferred medicines for protection. A number of women commented:

"I use *Groen Amara*, *Stuipdruppels* and *Haarlemensis* so that the child should not *gabola* (inhale) from other children or people who were strengthened with *dithare tsa setho* (medicine of the people - African medicine)".

"*Entressdruppels*, *Roilaventel*, *Duiwelsdrek*, *Borsdruppels*, *Haarlemensis*, *Stuipdruppels*, *Wonderkroon*, *Krampdruppels*, *Groen Amara* mixed helps to protect my child from inhaling from other children who have been strengthened by medicine taken from the *inyanga*."

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<sup>19</sup>A Soweto woman told me that although she is not superstitious in any way, she performs a little ritual "just in case". Every time when she has her baby with her and meets another baby who has been strengthened, the two infants are put back to back and both mothers take turns to pull on both babies' finger joints. She told me that by doing this they protect the unprotected baby. This ritual is a way to equalise the power between the two babies.

<sup>20</sup>In Pondo society, in the 1930s, children were thought to be in danger from a particular class of strong medicines (*amayesa*), and any one suspected of carrying them was asked to take the child with whom he is in contact and toss the child in the air (*ukulekeza*) that it may come to no harm from the medicine" (Hunter 1964:156). "... The medicines are believed to be harmful to children although he or she who carries them bears no ill will, and uses them for curative purposes. They harm children because they are 'too strong'" (Hunter 1964:156). The illness caused by contact with these medicines is the falling in of the infant's fontanelle.

<sup>21</sup>Africans make a distinction between *Dithare tsa Sesotho* or *Setho* (medicine of African culture) and *Dithare tsa Sekgoa* (medicine of White culture)

"If you use the "*stuips*" (*iteip*) the child will always be protected and never inhale bad spirits of people who use strong medicine. They are

*Behoedmiddel, Borsdruppels, Duiwelsdrek, Entressdruppels, Groen Amara, Haarlemensis, Stuijdruppels, Wonderkroon.*

"I mix *Entressdruppels* and *Stuijdruppels*. It protects the child against the *miniti* of people who attended a funeral where there were a lot of people mixing. The child will not be suppressed because it's not easy for the child to be affected when you use this kind of medicine - it will protect the child from inhaling".

### Bad spirits of witches

The third category of potential harm comes from the bad and sometimes dirty spirits of witches or sorcerers (*baloi* (Sotho) or *abathakathi* (Zulu)). This is a big problem for mothers who have to go outside with their baby to shop, to the clinic or to a childcare facility. The roads are treacherous because witches love gathering at busy streets and cross roads. At night these witches are often outside the house and although a person is not aware of it the child will be (see section on *Doepa*). An additional problem is that a mother cannot always be certain about who is a witch and who not, and this inadvertently harms her child. Therefore the mother needs to take the utmost caution to ensure that her child will be safe. A woman said for example:

"I use *Groen Amara, Haarlemensis, Stuijdruppels* and *Paragorise-Elikser* for protection so that child does not inhale the bad dirty spirits of *baloi* and *dingaka*<sup>22</sup> and so that if you move around with the child in streets, the child will not become sick".

"*Haarlemensis* and *Stuijdruppels* make the baby strong. They protect even the fontanelle and protect against inhaling *imimoya emiba ya bathakathi*. If the child doesn't inhale she won't get sick. They also make the baby's joints very strong".

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<sup>22</sup>There are two distinct types of African healers in South Africa, the diviner (eg. *isangoma*, Zulu; *ngaka*, Pedi) and herbalist (eg. *inyanga*, Zulu).

"I use *Haarlemensis* for protection against bad spirits of witchcraft. Babies do take things that are not meant for them because they are weak".

### Dirty spirits of Satan

The incorporation of Satan into the African belief system is clearly an influence from Christianity. The dirty spirits of Satan are omnipresent and may harm the child. The main way of keeping Satan away is by burning *Doeпа*, which is also used to chase away the *baloi* (see section on *Doeпа*).

"I burn *Doeпа* or *Imphepho*<sup>23</sup> to chase away the dirty spirits of Satan (*imimoya ka Satan*) that make children not to sleep at night".

### Suppressing

A few mothers protected their children from being "suppressed" (*gatega* or *getrap wees*). This literally means "to be stomped on" and often refers to a "depressed" or "sunken" fontanelle. "Suppression" is a problem especially when moving around with a baby. A mother could walk over the tracks (*spoor*) of people who had been strengthened with strong medicine and pick up the "heaviness" of their bodies which is very dangerous for a child. Women explained:

"*Haarlemensis*, *Stuipdruppels*, *Groen Amara*, *Wonderkroon*, *Duiwelsdrek*, *Behoedmiddel*, *Krampdruppels*, *Versterkdruppels*, *Rooilaventel* and *Entressdruppels* are so that child does not get suppressed (*gatega*) by people who use African herbs. If you give this to the baby he'll never be suppressed and he won't be affected by the "heaviness" of people's strong medicine and will be protected".

"I use *Haarlemensis*, *Stuipdruppels* and *Entressdruppels*. The baby must not be suppressed or must not go over "spore". When you give this to the child she will never inhale or be suppressed - not even a little bit wherever you go with him".

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<sup>23</sup>*Imphepho*=Zulu, while *Phepa Badimo*=Sotho (see section on *Doeпа*)

Suppressing and inhaling are closely related. Ngubane describes both as “environmental” dangers (Chapter 6).

### Children’s Illness

Infants must be protected against *malwetse a bana* (children’s illness). This type of illness is of a particular serious nature and includes conditions such as *kokwana*, *inyoni*, *phuagwana* and *lebetjane*. For some women this category of illness is the outcome of inhaling or suppressing:

“I use *Stuipdruppels*, *Krampdruppels* and *Rooilaventel* to prevent the child from getting children’s diseases (*malwetse a bana*) from children who have been strengthened by African medicine. It prevents the child from being suppressed and the child must not inhale. This child has never inhaled or had diarrhoea since birth”.

“I use *Haartemensis* and *Entressdruppels* to protect my baby from the bad spirits of people who use strong medicine (*emimoya e mibi ya bantu*). They protect the child’s fontanelle (*ikhakhayi*) from sinking because of inhaling bad spirits of strong medicine”.

Others are not sure about the origin of the illness but they are certain that these illnesses are life threatening and infants must be protected against them.

“*Groen Amara*, *Rooilaventel* and *Haartemensis* are used for the baby to get rid of green stools. If baby is not rid of green stools he will suffer from *inyoni*”.

“I apply *Haartemensis* on the baby’s head to protect the baby against *phuana* and give her a drop to drink. If you do this the child won’t take illnesses from other people (*mekhokha*)”.

I give the baby *Haartemensis*, *Rooilaventel* and *Pargoriese Elikser* to drink. They prevent *ukhakhae* (fontanelle) and *inyoni* and will protect the baby so that he won’t be affected by fontanelle or *inyoni*”.



"*Groen Amara, Haarlemensis* and *Stuipdruppels* protect the child from *phuana* and *kokwana*. Even if the child gets affected by *phuana* or *kokwana* as long as she bathes and takes *distuip* (Dutch medicines) she'll never be very ill".

## Being Frightened

A Soweto mothers protected their children against being frightened. The things their babies are frightened by range from loud noise, being tossed<sup>24</sup> up in the air, to being scared of the *baloi* or *abathakhati*. The problem is that children can see things that adults can not. One women told us that "a baby is like a *sangoma*" (diviner who has special powers to "see" things). Babies who are frightened will cry a lot, are restless, have fits and are troublesome (*meleko*).

## Soothing and Drugging

As discussed in Chapter 6, there is considerable pressure on mothers to keep their babies quiet and content. Almost 11% of the mothers gave Dutch medicines to their fretful infants to sooth them (Figure 8).

"A mix of *Borsdruppels*, *Duiwelsdrek*, *Entressdruppels*, *Groen Amara*, *Haarlemensis*, *Rooilaventel*, *Stuipdruppels*, *Versterkdruppels* and *Wonderkroon* helps a lot when baby cannot sleep. If you give him to drink he will sleep and you will be able to do your house chores".

Some mothers even openly admit that they drug their babies to sleep:

"I use *Stuip*, *Haarlemensis* and *Entressdruppels* to drug (*modruga*) the baby to sleep".

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<sup>24</sup>Hunter (1964:156) describes Pondo infants being tossed up in the air at a diviner's initiation ceremony in the 1930s.

All the Dutch medicines have alcohol as part of their ingredients, and in addition some contain opium tincture and valerian (Appendix C). From a health promotion point of view, the high alcohol content of Dutch medicines is one of the biggest worries when mothers give it frequently to their infants. Although many of the labels warn against giving the medicines to children under two years of age most people seems to disregard this.

### Umbilical Cord

Five percent of the mothers in this study said that they use Dutch medicines to treat the baby's umbilical cord. In a study by Richter (1994:24) mothers expressed the feeling that a baby needs to recover from birth and specifically that the "digestive system and the wound inside the child caused by the severance of the umbilical cord" need to heal. To help this recovery 38 mothers suggested the use of Dutch Medicine (especially *Groen Amara*), 29 thought that methylated spirits and a spirit mixture from the clinics would assure the baby's recovery. The remaining ten women thought Gripe Water, a bandage over the navel, and medicine from an indigenous healer should be used.

Similar reasons for treating the umbilical cord were suggested by women in my study:

"*Groen Amara* cleans the baby's cord (*khujwana*). If given this, the baby passes green stools to show that it's getting clean".

I use *Haarlemensis*, *Groen Amara*, *Behoedmiddel* and *Entressdruppels*. *Groen Amara* helps to heal the cord from the inside but I always use it with other druppels although I always use *Groen Amara* more than the others maybe 5 times a day 1 drop with 1 tablespoon of milk for a quick healing of the cord".

## Stomach Problems

Almost 7% of the women in this study used one or more Dutch medicines to treat stomach problems including diarrhea, cramps, colic, constipation, or flatulence (Figure 8).

*"Entressdruppels, Rooilaventel and Haarlemensis: They heal whatever problem the baby has in her tummy".*

The mothers using *Behoedmiddel vir Kinders*<sup>25</sup> for diarrhea are those who come closest to following any instructions on the bottles. They also do not mix *Behoedmiddel* with anything else.

*"I use Behoedmiddel for diarrhoea (letshollo). It will stop the baby from having diarrhoea for a long time. For a baby with diarrhoea until 2 ½ years old use 1 teaspoon full once a day but if diarrhoea does not stop should take baby to the clinic".*

The mothers who were treating cramps, colic, constipation and flatulence were mixing various Dutch medicines, some giving it when needed and others as a precaution.

*"For flatulence and colic use Haarlemensis, Stuipdruppels, Groen Amara, Behoedmiddel, Wonderkroon, Borsdruppels, Duivelsdrek, Versterkdruppels and Entressdruppels. It relieves the child from wind in the stomach and gets rid of colic".*

*"Use Haarlemensis for colic and cramps. It stops the cramps in the baby's tummy Only when the baby has got cramps until 2 to 3 years".*

*"I use Borsdruppels, Entressdruppels, Haarlemensis, Jamaika gemmer, Rooilaventel, Stuip and Wonderkroon. I think they also help the baby to break wind because it is written on the labels that they do. I use to give it once a night everyday before the child was six months old but now I seldom give him".*

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<sup>25</sup>*Behoedmiddel vir Kinders* is according to the Lennon's Dutch Medicine Handbook "a most effective and reliable remedy for most stomach and teething complaints in infants. Since it contains no opiates or other harmful drugs it can be given with safety and complete confidence to infants of all ages".

## Uncertain

Nine percent of the women could not give a reason why they used Dutch medicines other than to say that it was a tradition in their family, their mothers or grandmothers told them to do it or they saw their neighbors or friends use it. A few people could not give any reason whatsoever.

"I put a drop of *Groen Amara*, *Haarlemensis* and *Stuip* in the baby's bath because my grandmother said so".

"We use *Haarlemensis*, *Stuipdruppels*, *Behoedmiddel* and *Rooilaventel*. Most of the things were done by my mother for my child and I do not know for what reason".

"I use *Haarlemensis* and *Entressdruppels*. I don't know for what reason. My mother said she used this medicines on all her babies so she said I must also use them for my babies.

## How to Achieve Total Protection

There are many different ways of using Dutch medicines (Figure 9) . Most women (81.9%) follow a daily ritual (one to three times per day) of applying Dutch medicines to the infant. The most popular method was to add drops of the different medicines to the child's bath water and then afterwards to give the child a drop of each medicine to drink in a teaspoon with breastmilk, water or cow's milk. By bathing the baby its total body gets covered.

"I use *Groen Amara*, *Haarlemensis*, *Stuipdruppels*, *Borsdruppels*, *Behoedmiddel*, *Wonderkroon*, *Duiwelsdrek*, *Krampdruppels*, *Entressdruppels*, and *Rooilaventel* twice or 3 times a day until my mother tells me to stop because she is the one who said I must use them. I put a drop of each in baby's bath and then give a drop of each on teaspoon mixed with breastmilk.

Some women only gave their children medicines to drink (15.3%) or only bathed their babies in the medicine (15.3%). Smaller numbers only rubbed it on the child (11.9%), or used a combination of rubbing and drinking (4.5%), or a combination of rubbing, bathing and drinking (1.1%).

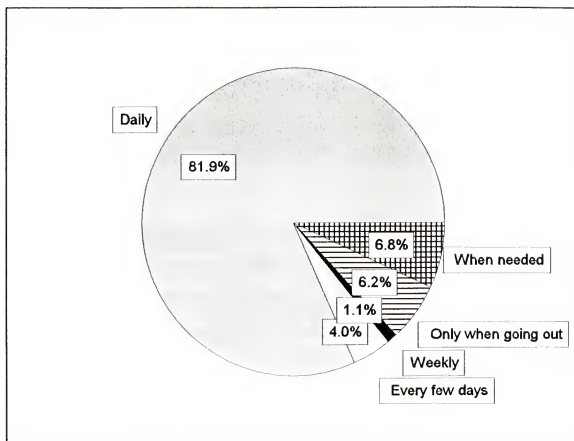
*"I use Stuijdruppels, Haarlemensis and Wonderkroon. I wash the baby with water and soap two times a day and then I smear the child with Vaseline which is mixed with druppels all over the body and then a drop of each bottle mixed with milk and give it to the baby".*

*"I use Groen Amara, Stuijdruppels and Haarlemensis once every day maybe until the child is one year old. I put one drop of each medicine in the baby's bath and if ever I am going somewhere with the baby I will apply Haarlemensis under her feet, in earholes and on fontanelle with fingers and also on private parts"*

The smearing is in all the orifices: ears, nostrils, anus, fontanelle, private parts, as well as under the feet and sometimes on the palms of the hand. These are all the areas of a baby that are considered soft and vulnerable to "foreign invasion" by for example bad spirits. The daily rituals continue for the most part of the infants first year of life, often until the first birthday.

An interesting aspect of giving the medicines by mouth is that many babies have their own teaspoon for the duration of the "treatment".

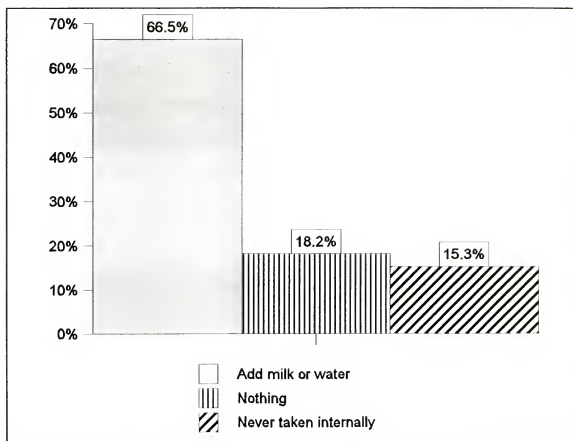
*"We never use the baby's teaspoon for any other use because then the druppels will have no effect"*



9 Frequency of Using Dutch Medicines for the Child (n=177)

### Side Effects

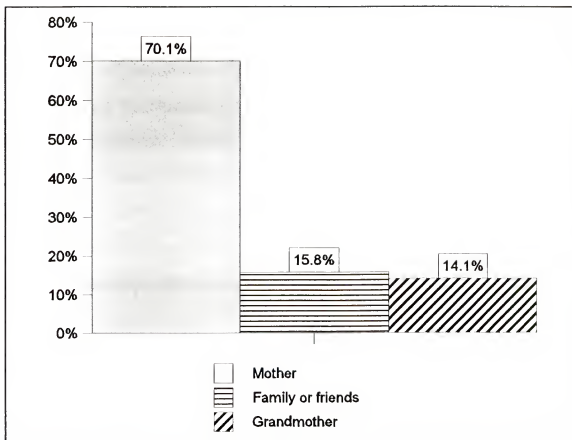
Although the women were completely unaware of specific side effects of the medicines, some (15.3%) were adamant that the child should not drink them because they are too strong for a small child and the majority agreed that the drops should only be given in milk or water (66.5%)



10 Kinds of Precautions Necessary with Giving Dutch Medicines to the Child (n=176)

### Source of Knowledge

The majority of women (70.1%) were told by their mothers about the use of Dutch medicines (Figure 11). Other family members and friends also play a role (15.8%), while grandmothers were the source of information in 14.1% of the cases.



11 Person Who Encouraged Mother to Use Dutch Medicines (n=177)

### Source of Medicine

Most women (63.6%) buy their Dutch medicines from the pharmacy with a smaller number buying it from a store. Women seem to have greater trust in the medicines bought from the pharmacy. As one woman said: "Chemists make sure that they don't sell expired medicine".



### *Doepa*

*Doepa* is probably the most interesting Dutch medicine from a historical perspective. It is the popular name of Benzoin B.P.C<sup>26</sup> (Benzoin). According to the British Pharmacopoeia (1958:85) and, Trease and Evans' Pharmacognosy (Evans 1989:326) Benzoin (Sumatra Benzoin or Gum Benjamin) is the balsamic resin of the incised stem of *Styrax benzoin* Dryand, and *Styrax paralleloneurus* Perkins (Fam. Styracaceae). It is only produced from cultivated trees in Sumatra, although the tree is also indigenous to Java and Borneo.

Benzoin is described as:

"brittle masses consisting of opaque, whitish and reddish tears embedded in a translucent, reddish-brown or greyish brown, resinous matrix. Odour, agreeable and balsamic but not very marked; taste, slightly acid".

"When gradually heated, benzoin evolves white fumes of cinnamic and benzoic acids which readily condense on a cool surface as a crystalline sublimate" (Evans 1989:327).

Ibn Batuta, who visited Sumatra in the 14<sup>th</sup> century, described the drug but it was not regularly imported into Europe until the 16<sup>th</sup> century (Evans 1989:326). And a narrative by Duarte Barbosa (stretching from 1511 to 1516) for example describes benzoin as one of the drugs found in the drug markets in the Orient, together with camphor, aloes, tamarind, cassia, sandalwood, rhubarb, myrobalan, opium, nutmeg, pepper (Guerra 1966:50). Balms such as Sumatra Benzoin, Tolu Balsam (from Colombia and Venezuela)

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<sup>26</sup>The formulae are equivalent to the British Pharmacopoeia or the British Pharmaceutical Codex Preparations

and Copaiba Balsam (from Brazil) were all used in the treatment of wounds and used as incense in Europe<sup>27</sup> (Guerra 1966:38-39).

*Doepa* does not appear in any of the pamphlets from the 1800s. It seems to have become "officially" part of Dutch medicines in the 1900s. The origin of *Doepa* in South Africa can be traced back to the slaves<sup>28</sup> that were imported from the East, although the best evidence for this is in the word itself.

*Dhūpa* is described in a glossary of Indian religious terms and concepts as an incense stick that emits a fragrance when burned. "It is required in the worship of deities" (Bhattacharyya 1990:54) as one of five *Upacāras*<sup>29</sup> (presentable articles), which are offered in worship (Bhattacharyya 1990:105). However, the word can be traced back to the Sanskrit word meaning incense and to *Dhūpana* meaning incensing or fumigation (Turner 1966:392). An 1899 Sanskrit-English Dictionary clarifies the meaning of *Dhūpa* as "incense, perfume, aromatic vapour or smoke proceeding from gum or resin" (Monier-Williams 1899:517). There are many related words in the Indo-Aryan languages meaning

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<sup>27</sup>Today, in Europe, it is mainly used as an ingredient in Friar's Balsam, as a cosmetic lotion or as a component of incense. It is also used in food, drinks, perfumery and toiletry industries (Evans 1989:326).

<sup>28</sup>Jan van Riebeeck had specific instructions from the Dutch East Indian Company not enslave indigenous people of the Cape. Therefore the first slaves were imported; mainly from West Africa. Later slaves were brought from Madagascar and Mozambique, but the most prized slaves were from the East - the present-day Java, Bali, Timor, the Malaysia and China. Slaves were also imported from India (Reader's Digest Association of South Africa 1988:48-50).

<sup>29</sup>Five (*pañcopacāra*) *Upacāras* (materials) are offered in worship. "They are: *pādya* (water as the symbol of the element *ap*), *ganda* (sandal, etc as the symbol of the element *prthivī*), *puspa* (flower as the symbol of the element *ākāśa*), *dhūpa* (incense as the symbol of the element *vāyu*) and *dīpa* (light as the symbol of the element *tejas*)". "This *pañcopacāra* was later elaborated into ten (*daśopacāra*), sixteen (*sodaśopacāra*), and at times even to sixty-four" (Bhattacharyya 1990:117).

"smoky fire", "exorcising with aromatic smoke", "to expose to smoke, let smell smoke" (Turner 1966:392). In Indonesia and Trinidad the word Dhoop or Dhup<sup>30</sup> is used in the Hindu tradition for incense that is burned to keep evil spirits away.

Over time, through the slaves and Malaysian exiles to the Cape, the word and related substance first entered, the Afrikaans folk traditions and later it was incorporated into African cultures where it is known as *Dupa*.

The word *Doepa*, commonly used in Afrikaans, has many meanings reaching far beyond *Doepa* as a medicine or a drug. Most of the meanings are related to magic. The HAT<sup>31</sup> describes the meaning of *Doepa* as: a Cape Malay *reukwerk* (incense); *toormiddel* (charm), *liefdesdrank* (love potion), *toorgoed* (magic object), while the WAT<sup>32</sup> (1955:223) elaborates its uses as a noun: (i) an incense from a tree that the Cape Malay burn in their homes or mosques for its pleasant smell and (ii) the brand name for benzoin resin pieces, crushed to a powder that is burned by "*nie-blankes*" (non-whites) in their sick-rooms against chest ailments and the liquid used as a *versterkmiddel* (tonic) and remedy against wind, fits, and as a lotion. But it also means, according to "*nie-blanke bygeloof*" (non-white superstition), a secret *toormiddel* (magic potion), *geslagsdrif-* of *liefdeswekkende middel* (aphrodisiac), *toorspreuk* (magical saying), *liefdesdrank* (love potion), *toorgoed* (magic object), *paljas* (spell or magic potion). As a verb the meaning is *verlief maak* (to make someone fall in love), *bekoor* (to charm), *betower* (to enchant), *toor* (to put a spell on).

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<sup>30</sup>Khumar Noor Mahabir University of Florida 1997 Personal communication.

<sup>31</sup>*Handboek van die Afrikaanse Taal* (Handbook of the Afrikaans language).

<sup>32</sup>*Woordeboek van die Afrikaanse Taal* (Dictionary of the Afrikaans language).

*Doepa* could also mean any illegal substance given to a horse to improve its performance during a race.

### Types of *Doepa*

I found four kinds of *Doepa*. The first and best known is *Doepa* (Benzoin B.P) in a can packaged by Lennon's. It is described by the Lennon's Dutch medicine handbooks (ca 1960 and ca 1980) as a "preparation (that) gives relief in cases of wind, flatulence and colic and can be taken for minor kidney and bladder complaints. It should be crushed and from ¼ to ½ teaspoonful taken 3 times a day".

There is also *Doepa-olie* (Balsamum Peruvianum B.P. or Balsam of Peru) sold as a Dutch medicine by Lennon's and discontinued sometime after the 1970s. Figure 12 contains a description of *Doepa-olie* as contained in the Heynes Mathew pamphlet (1951:10) and the ca1960 Lennon's Dutch medicine handbook.

<i>Doepa-olie</i>	<i>Doepa-olie</i>
Heynes Mathew 1951	ca1960 Lennon's Dutch Medicine Handbook: Home Remedies.
For external use. It makes a very good antiseptic ointment against parasites when mixed with lard - this is also very good for festering wounds. For internal use take 5-15 drops for chest illnesses and to loosen phlegm"	A useful remedy for coughs, croup and bronchitis. Five to 15 drops should be taken on sugar or mixed with water. Externally. Mixed with lard, it is a useful antiseptic ointment.

12 Descriptions of *Doepa-olie* in Two Different Dutch Medicines Pamphlets

Recently two other kinds of *Doepa* appeared on the streets of Johannesburg available from street vendors. The one is called Extra Strong Special *Doepa* (also known as Wet *Doepa*) It is sold in a plastic container by Sanjay's Quality Products (\$2). The other is known as *Doepa Mnyama* (or Wet Black *Doepa*, referring to the texture) sold in a plastic container by Muti Medicines (\$1.50). Neither of the containers carry any instructions for use. The customers are reportedly all African. It is not clear how popular the last two *Doepas* are.

### *Doepa* Use in Soweto

The use of *Doepa* presents another variation of Dutch medicine. Among the group of women who reported using *Doepa*, only 35.5% were committed to using only *Doepa* (Figure 13). A group of 27.6% were using *Doepa* and a herb *Imphepho*<sup>33</sup> interchangeably, while another group (31.6%) reported using *Imphepho* by itself (for the same reasons others were using *Doepa*). Four women were using a combination of *Doepa* and *Imphepho* or *Doepa* and *Haarlemensis*. One woman explained that:

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<sup>33</sup>Zulu names: *impepo*, *imphepho* Genus *Helichrysum* Mill. Herbs, shrubs or subshrubs, sometimes dwarf and cushion-forming, sometimes aromatic (Hutchings et al 1996:318-320).

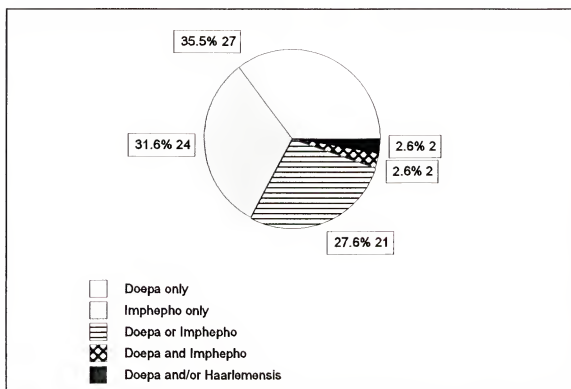
*Helichrysum decorum* DC.; *Helichrysum epapposum* H. Bol.; *Helichrysum gymnocomum* DC.; *Helichrysum natalitium* DC: The smoke from the leaves and stems of the plants are burned and inhaled by izangomas (diviners) to induce trances or burned by people as incense to invoke the goodwill of the ancestors (Hutchings et al 1996:318-320).

*Helichrysum odoratissimum* (L.) Sweet: "Leaves and stems are widely used as incense to invoke the goodwill of the ancestors and in other forms of traditional medicine. Plants are widely used in Transkei, burned to invoke the goodwill of the ancestors, inhaled as protective cleansers and used in medicines for coughs and colds". "In Lesotho, plants are burned to fumigate sick-rooms"(Hutchings et al 1996:320).

"You can either use *Doepa* or *Imphepho* because they are one and the same so you change them" (Zulu mother).

It could be argued that what we see with the interchangeable use of *Doepa* and *Imphepho* represents an example of the indigenisation process of one of the Dutch medicines. While some people are still using *Imphepho*, others use both *Doepa* and *Imphepho* interchangeably as if they were the same, while others have made the complete switch to *Doepa*. *Doepa* is thus being incorporated into the local African healing tradition through a process of reinterpretation in terms of local beliefs..

Both *Doepa* and *Imphepho* are used to soothe restless and crying babies (Figure 14). Twenty one (27.6%) of the mothers burn *Doepa* or *Imphepho* to make their babies go



13 Percentage of *Doepa* and/or *Imphepho* Users (n=76)

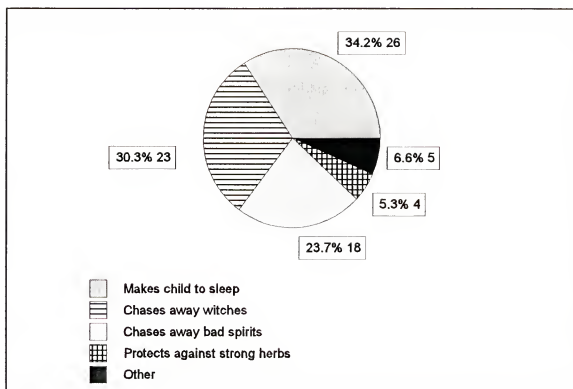
to sleep or to drug (*mudruga*) their babies to sleep.

"When my baby is restless at night I burn *Doeпа* or *Imphepho* on the stove and make my baby inhale the smoke. It will drug (*mudruga*) the baby".

Mothers often attribute their infants' fretfulness to fear for things in the dark outside the house:

"I first see if the baby is not sick or hungry or try to find out what makes the baby to cry and then try to give her some Panado. If it does not help then I will burn *Imphepho* - it will sooth the baby".

These frightening things that you have to chase away with *Doeпа* or *Imphepho* are outside the house, in the yard or sometimes on the roof. Twenty three women were using it to chase away *imimoya emibi ya baloi/bathakathi* (bad/dirty spirits of the witches/sorcerers), eighteen mothers chase away *memoya emebe* (*imimoya emibi*) (bad



14 Reasons Provided by the Soweto Sample for Using *Doeпа* and/or *Imphepho* (n=76).

spirits), while one mother used it to chase away *imimoya ka satan* (bad spirits of Satan).

Children are sensitive to any evil, bad things or bad persons, evil spirits or too much strong medicine at least until they turn one. God created children like that, they say. Witches never like children because they will expose them. Infants can "see" things that adults can't - "a baby is like a sangoma".

"I use *Imphepho* when my baby cries and does not sleep at night or when there are bad spirits in or outside the house".

"Children use to cry in the house and say they saw a short thing that looks like a person, saying this while crying. We were helped by burning *Imphepho* and they don't see that thing any longer at night. It will chase away the spirit of *baloi*".

"I use *Imphepho* for protection against "bad spirits of herbs" that people in the neighbourhood burn at night to protect themselves against all kind of things".

"I use *Imphepho* for protection against spirits of people who are witches (*Imimoya e mibi ya bantu a bathakathayo*)".

"When the child does not sleep at night because of the *baloi* or anything bad in the house or in the yard I burn *Imphepho*".

"The baby will sleep if you burn *Imphepho* because *Imphepho* is stronger than any other "African medicine" (*dithare tsa setho*)".

"When you burn *Imphepho* it chases away the spirits of *baloi* because the smell of *Imphepho* is stronger than the smell of other herbs".

"When there are bad spirits of *baloi* that make the baby not to sleep at night *Doepa* with *Haarlemsis* chase spirits away because they are both very strong against bad spirits. Burn *Doepa* on hot plate in an empty small polish lid and when it burn put a drop of *Haarlemensis* on top of the *Doepa* and let the baby inhale the smoke".

As is true for all the Dutch medicines, the way people used them over time constantly changed. The uses have often nothing in common with the intention of the manufacturers. Burning *Doepa* to ward off illness and specifically to protect children



against “spirits” shows remarkable similarities with the way in which it was used during the 1918 flu epidemic. In 1965, the South African Academy for Arts and Science<sup>34</sup> published a collection of Afrikaner folk remedies. Number 6296(b) refers to the extensive use of *Doepa* during the 1918 flu epidemic: “Take one big spoon of *Doepa* and burn it on a saucer with red coals in every room. It will take away germs, *goëlery*<sup>35</sup> and *spoke*<sup>36</sup>.” or will help to relieve a headache<sup>37</sup>.

Brindley (1976:23) reported that there is “evidence of protective magic” in the Western Coloured Township, in Johannesburg. She found that mothers put “garlic, cloves, camphor, *Duiwelsdrek*, *Entressdruppels*, *Doepa*, dry mustard and *Haartemensis* (in various combinations) in a little bag and hang this on the neck of the eldest son or daughter for the first six or nine months of life, basically to protect the child from becoming polluted and weakened by others”. “Hy sal nie die geestelike goete kry en al die vuiligheid van baie mense...” (He won't catch the spirit things and all the dirt of many people...). Although many years apart, both examples of the use of *Doepa* sound remarkably similar to the reasons Soweto mothers give for using *Doepa*:

“*Doepa* is stronger than the bad spirits of the witches (*bathakathi*). It chases the spirits of witches away” (Zulu mother).

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<sup>34</sup> Volksgeneeskuns in Suid-Afrika: 'n Kultuurhistoriese oorsig, benewens 'n uitgebreide versameling Boererate Part I & Part II.

<sup>35</sup> *Goëlery* means poltergeists

<sup>36</sup> *Spook* means ghost

<sup>37</sup> #2647 “For a headache: Burn a few *Klipspringer*hairs, 12 cloves, 1 piece of *Doepa*, 1 piece of bees wax (the size of a 3d). Inhale the smoke”. In size 3d refers to a coin that resembles the size of a dime.

"Put *Doepa* on a red coal and let the smoke fill the house. It will help against bad spirits. Sometimes when we sleep we hear things moving on top of the house or in the yard - those things make the baby not to sleep" (Zulu mother).

The way to use *Doepa* or *Imphepho* is to burn it on the stove in the lid of a polish can or a red coal and let the smoke fill the house, or let the baby inhale the smoke or move the child over the smoke to cover all the body orifices. Women seems to prefer that the child inhale (*gabole*) some of the smoke before turning in for the night (Table 9).

"Burn *Imphepho* on the stove and let the smoke fill the house. After you have burn *Imphepho* nobody should go outside house because bad spirits will come in the house and the *Imphepho* will lose its strength/power"

9 The Ways *Doepa* and/or *Imphepho* Are Used (n=76)

	BABY SHOULD INHALE THE SMOKE	FILL THE HOUSE WITH SMOKE	COVER BABY WITH SMOKE
<i>Doepa</i> alone	13	13	1
<i>Imphepho</i> alone	14	10	-
<i>Doepa</i> or <i>Imphepho</i>	14	6	1
<i>Doepa</i> and <i>Imphepho</i>	2	-	-
<i>Doepa</i> and/or <i>Haarlemensis</i>	2	-	-
TOTAL	45	29	2

The Soweto mothers traced the practice of burning *Doepa* and/or *Imphepho* back to their mothers and their grandmothers. Fifty four mothers and 11 grandmothers suggested the use of either *Doepa* or *Imphepho*. In some cases it was the woman herself, friends or a mother-in-law who suggested the use. Women overwhelmingly bought *Doepa*

at the chemist and sometimes at a store. The *Imphepho* is bought from a herbalist store, Kwezi station in Soweto, or from a *Bomkhozi* (a woman who walks in the streets selling herbs). The women were all unaware of any potential side-effects from either *Doepa* or *Imphepho* but they all agree that neither *Doepa* nor *Imphepho* should be administered orally.

### Summary

Different kinds of Dutch medicines are used by 80% of the Soweto mothers interviewed to protect their infants from potentially harmful things around them (bad tracks, things in the air and witches). Parents can try to avoid dangers, but it is not always possible. Therefore they have to use protective medicines. Although a professional, such as a indigenous healer, can apply the prophylaxis, many parents prefer to do the protection themselves. In Soweto Dutch medicines have taken the place of herbal protective treatment.

## CHAPTER 9

### MUTI WENYONI: MEDICINE FOR A SUNKEN FONTANELLE

#### Introduction

*Muti Wenyoni* is the name used by several pharmaceutical companies for an over-the-counter antacid specifically marketed for African babies. At the time of the research I identified six<sup>1</sup> different types of *Muti Wenyoni* (Appendices D and E). *Muti Wenyoni* is an excellent example of how indigenous beliefs are used by the pharmaceutical industry to promote a product with very little real value.

The history of *Muti Wenyoni* goes back about 50 years. A meeting between an African healer and a pharmacist resulted in a bottled version of an indigenous remedy for the illness *inyoni/kokwana* and *phuguana*. The proliferation of useless products with misleading names and indications in African languages resulted for two reasons: (a) The lack of specialist knowledge in Department of Health about the "African medicines" industry and (b) over the years there was a slackness in enforcing regulations on this market .

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<sup>1</sup>Two of the original *Muti Wenyoni* have changed the words on the medicine covers, since the research started, to comply with the regulations on labeling.

### ***Muti Wenyoni and a Sunken Fontanelle*<sup>2</sup>**

Diarrhea, but especially the dehydration and sunken fontanelle, is not always understood in terms of "physical" causes. In many parts of the world, including Africa, forces outside the body, social or spiritual, are often associated with a sunken fontanelle (De Zoysa et al 1984:727; Meldrum 1984:184). The sunken fontanelle or *caida de mollera* is for example a well known culture-bound syndrome<sup>3</sup> in Latin America (Trotter et al. 1989:211). It is also a common syndrome in Pakistan where it is known as *sutt* and requires treatment with traditional remedies or by traditional healers (Helman 1996:9-10).

In many cultures people believe that small children need special protection because they are very vulnerable, especially to diarrhea associated with a sunken fontanelle. Therefore mothers do different things to protect their infants from this condition. Yoruba market women, for example, give their children a variety of pills and potions on a regular basis to protect the children and keep them healthy (Meldrum 1984:184). This is also the case in South Africa.

A recent study by Soul City<sup>4</sup> pointed out that many black South African communities recognize more than one type of diarrhea. Aside from ordinary diarrhea associated with teething, inappropriate food and so on, there is also diarrhea associated

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<sup>2</sup> The fontanelle tends to sink in states of dehydration, making it a useful sign in such conditions as gastro-enteritis.

<sup>3</sup> Cultural specific illnesses with associated etiologies and therapies unique to members of a particular group or groups.

<sup>4</sup> Soul City is the name a multi-media community health project which includes a television and radio drama series, a weekly newspaper column, and a summary booklet at the end of each series.

specifically with *Inyoni*. There are many regional and cultural variations in the terminology, explanation, and treatment of *Inyoni*. The current explanations of *Inyoni* in the urban setting seems to be a blending of different cultural traditions. *Inyoni* is explained as a life threatening condition where a "snake" or a "worm" is eating the child's "insides". This condition, if untreated, leads to *Hlokwana* which results in a sunken fontanelle.

Several old studies refer to the conditions of *Inyoni* or *Phugwana*. Hellmann writing about the people of Rooiyard, describes the belief in a "Basotho sickness" caused by contact with a Sotho. Her description sounds very similar to the present day description of *Kokwana/Inyoni*:

Adult Sotho have medicine which enters the stomach of the child and there turns into a snake. This snake eats away the stomach of the child and causes its excreta to turn green. Even the breath of a Sotho may cause this evil result and it is also believed that the protective medicine given to Sotho children is so powerful that, on contact with other children it causes the "Basotho sickness" (Hellmann 1948:60).

Jali for example mentions that *Isolo*<sup>5</sup>, or *Inyonf*<sup>6</sup> or *Umkhondo*<sup>7</sup> is believed to be one of the most dangerous diseases. The problem starts with a mild diarrhea and ends with pneumonia and death (Jali 1950:18). This is a condition that attacks both girls and boys from birth to three years of age. Although common throughout the year it occurs more frequently in the summer.

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<sup>5</sup> Means suspicion.

<sup>6</sup> Means bird.

<sup>7</sup> Means track or spoor.

It is believed that the baby contracts it before birth. It is said that if a pregnant woman walks over or passes near a spot struck by lightning, she inhales lightning smoke; this goes into her womb and there comes in contact with the baby (Jali 1950:18).

Jali reports on a belief that a pregnant woman could be infected with *iso/o* any time between conception and childbirth. Some people believe that the woman's husband inadvertently could transmit the illness to his unborn child by touching or kissing his wife after he had contracted the disease from walking over a spot struck by lightning (Jali 1950:18). Some of the other things that render a baby vulnerable to *Inyoni* include: an extramarital relationship by the child's caregiver, a ritually unclean person entering the house of the baby, the baby being in close proximity to a person with "strong" medicine for example *stuip*<sup>8</sup> or *mohato*,<sup>9</sup> or the caretaker of the child crossing the tracks of a person who had been strengthened by African medicine.

The signs and symptoms are explained as

frequent loose stools, greenish and stringy, with offensive smell. There is rapid loss of weight and emaciation. The anterior fontanelle becomes depressed and there is a white patch in the roof of the mouth. Finally the baby coughs, has rapid breathing and breathlessness. If not treated death is inevitable (Jali 1950:18).

*Inyoni* and its outcome, a sunken fontanelle, are usually perceived as the result of social or spiritual forces operating from outside the body. A child with *Inyoni* is usually

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<sup>8</sup>*Stuip* is a popular name for the Dutch medicine *stuipdruppels*.

<sup>9</sup>Hugh Ashton (1943:5) wrote about *mohato*: "(it) is normally used by smearing an infant's head to protect it from sorcery and from harm which might come to it through crossing unfrequented paths. But in the hands of a sorcerer it can kill or maim a child. Its effect depends entirely upon the purpose to which it is put."

frightened without reason, unhealthy, or has a "grumbling" or bloated stomach. Small children are particularly weak and vulnerable to *lonyoni* and therefore need special protection against this serious condition. Phillips stressing the importance of the treatment practice by quoting the following:

... (paid) £7 to a witch-doctor for magic medicines to guard her baby against the falling of the fontanel. This is a general practice, Miss Cowles states, among many of the Transvaal tribal Bantu. Furthermore, every child has to be vaccinated (*phogoane*) according to native fashion. They must be 'passed through the smoke'. This means Native medicines. A well-educated, Christian mother may be intellectually convinced of the futility of these measures, but she nevertheless arranges for this double-precaution, 'just in case' (Phillips 1938:133).

The treatment can take on a variety of forms. It usually involves a prophylactic that which strengthens the child with "medicine" (or *muti*) which is smeared on the child, burned for inhalation or taken by mouth, or the treatment could be curative<sup>10</sup>. Jali (1950:18) writes that both types of treatment is carried out on top of a mountain after an appointment has been made with an *Iso/o* specialist. The specialist finds a spot recently struck by lightning and the diagnosis of the type of *Iso/o* is made before the treatment starts.

A commonly practiced custom related to the treatment of *Iso/o* is that of smoking the baby with *Izinyamazane* (parts of animals' flesh, organs, hair or feathers). A piece of medicine is put on a live coal so that smoke begins to rise from it. The baby is passed over it so that it may inhale the smoke. Little scarifications are made with a sharp unsterilized instrument over the anterior fontanelle and on the joints of the body such as wrists, ankles, knees and hips. A herbal mixture is ordered for three days, this being followed by an enema which is said to have a cleansing effect on the bowels (Jali 1950:19).

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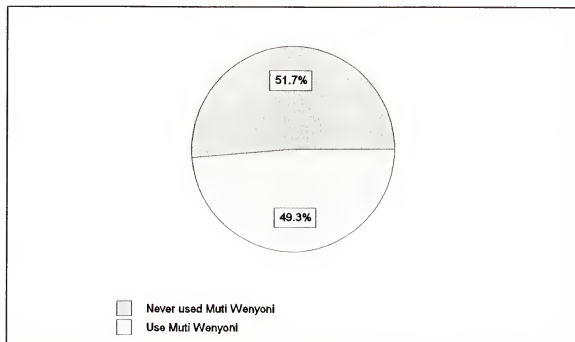
<sup>10</sup>(Brindley 1976:22) "Some (coloureds) heat the leaf (castor-oil) and place it on a flannel to use as a poultice. One mother rubs all her infants with castor-oil on the temples, forehead, palms of the hand and soles of the feet to keep the *vuiligheid* (dirt) away, and she swears by it as a protection against gastro-enteritis. She no longer administers castor-oil internally because 'the new castor-oil is not as good as the old': it makes the child too weak by overworking the stomach"



In the past, African caregivers used herbal remedies (including a herbal mixture known as *Muti Wenyoni*) in the belief that it protected their infants from *Inyoni*. Herbal mixtures known as *Muti Wenyoni* can still be obtained from African healers but are usually much more expensive than the different antacids that have been packaged and labeled *Muti Wenyoni* and are readily available from pharmacies and retail stores. For example, a herbalist in Diepkloof Soweto sells his *Muti Wenyoni* herbal mixture for R35 (\$7), while the bottled antacid known as *Muti Wenyoni Mixture* (75 ml) is sold by him for R7 (\$1.5). *Muti Wenyoni Mixture* is also available from pharmacies and retail stores for about R5 (\$1).

### Soweto Mothers and *Muti Wenyoni*

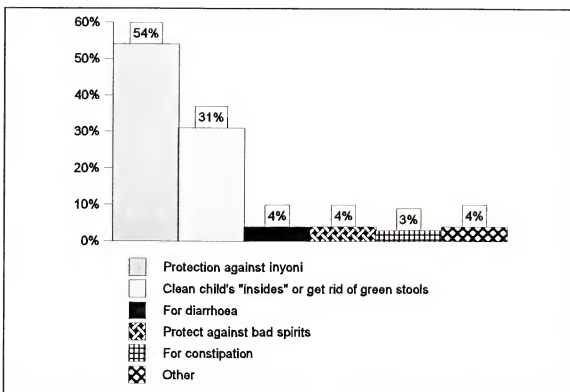
Research for this study revealed that 49.3% of the mothers (Figure 15) had used one of five brands of *Muti Wenyoni* for their children (Appendices D and E).



15 *Muti Wenyoni* Use by the Soweto Sample (n=211)

*Muti Wenyoni Mixture* was the most popular brand, used by 93% of the sample who used *Muti Wenyoni*. Seven women used *Muti Wenyoni* for the child but had stopped by the time we were interviewing them because of side effects such as the child losing its breath after taking a spoonful of undiluted *Muti Wenyoni*.

Fifty four percent of the women used *Muti Wenyoni* specifically as a precaution against *Inyoni*, while 31% used it to clean their child's stomach to get rid of "green stools". The remainder used *Muti Wenyoni* to stop diarrhea, for constipation, against restlessness, or to protect against evil spirits. See Figure 16 for a breakdown.



16 Reasons for Using *Muti Wenyoni*

Mothers explained that:

*(Muti Wenyoni is) "protection against Inyoni."*

*"If the child has Inyoni, the eyes will sink in. Muti Wenyoni will help to give the child strength and the child will get better."*

*(Muti Wenyoni) " gets rid of Inyoni before it can attack the child."*

Green stools are often associated with *Inyoni*, in different ways. Some caregivers see the green stools as a sign of *Inyoni*'s presence in the child's stomach and they have to get rid of it, while others see green stools as "dead *Inyoni*".

Mothers told us:

*"Muti Wenyoni will get rid of the green stools in the child's stomach - if you don't get rid of it the green stools make the child have Inyoni."*

*"If the child does not pass green stools the child will have Inyoni. Muti Wenyoni protects against Inyoni."*

*"If you give the child Muti Wenyoni the child will not be affected by Inyoni because it will be killed in the inside and then the child will pass green stools, which is dead Inyoni."*

But green stools is often seen as a sign of "dirt" in the infant's stomach causing illness to the child. Women use *Muti Wenyoni* to get rid of the "dirty green stools".

Two of the women we spoke to explained:

*"The dirt and green come out" (after using Muti Wenyoni).*

*(I use Muti Wenyoni) "because the baby will pass green stools and never get sick."*

The daily dosage ranged from a few drops up to four teaspoons per child and most women administered *Muti Wenyoni* daily for 10 to 12 months. Some women continued to

use *Muti Wenyoni* until their child was two to three years old. Most mothers were unaware of any potential side effects associated with the use of *Muti Wenyoni*. A few women told us that it is important to mix *Muti Wenyoni* with milk before giving it to the child to prevent the child from losing its breath.

Knowledge of the medicine came from the women's mother or grandmother in 68,3% of the cases, while the rest of the women were influenced by other family members, friends or neighbors or decided on their own to use it. Although *Muti Wenyoni* is available at African healers, most women (69%) interviewed, bought *Muti Wenyoni* at pharmacies, while 31% obtained it from retail stores.

The use of *Muti Wenyoni* by the Soweto sample illustrates the incredible waste of money on unnecessary over-the-counter medicines. The overall expenditure for those who used *Muti Wenyoni* was an average of R111 (\$24) per child for the duration of the treatment, while the group of women interviewed, together will spend R 11,000 (\$2,200) for the total treatment of their children.

### **So What Is Wrong with Supply and Demand?**

Diarrhea is a leading cause of infant deaths worldwide. It is also a major health problem for children under five years in South Africa. Diarrhea is the most common cause of infant death in the coloured community and the second most common cause amongst black children (Wilson and Ramphele 1989:112-113). In 1984, for example, diarrhea accounted for 39 percent of deaths of black children between one month and five years old and in 1986, 27,5 percent of all infant deaths in South Africa were due to diarrheal-

related causes (Wilson and Ramphele 1989:112). Nevertheless, it is black and coloured children younger than one year that remain most at risk (Yach et al. 1989:472-475).

Diarrhea is not only responsible for thousands of deaths but is also one of the major contributors to malnutrition, poor health and inadequate development of infants. According to Coetzer and Kroukamp "The average African child will have 4.9 attacks of diarrhea annually, each lasting five or six days. This means that the average child will have diarrhea and lose weight for a month each year. Although serious dehydration occurs in only 1% of diarrheal episodes, this will be the cause of 60-70% of all diarrheal deaths" (Coetzer and Kroukamp 1989:465).

The infants most vulnerable to diarrhea, grow up in poor overcrowded communities that often lack access to clean water and adequate sewerage disposal. Therefore, the primary way of preventing diarrhea is the improvement of water supply, sanitation, and sewerage. Some simple measures at the household level can also help to improve the situation, for example hand-washing, breast-feeding, and proper disposal of excrement.

### Diarrhea and Dehydration

Diarrhea is caused by different kinds of viruses, bacteria, parasites and amoebae, but it is also associated with the use of some drugs for example antibiotics. Furthermore it can be brought on by stress, tension and change of diet, as well as by measles (Chetley 1993:28). Diarrhea can last from a few hours to several weeks. Through diarrhea the body removes alien toxins, bacteria, or other materials upsetting the gut. The biggest problem with diarrhea is the accompanying dehydration due to the loss of large amounts of body

fluids and electrolytes. The symptoms of severe dehydration in infants include a sunken fontanelle, sunken eyes with no tears, a dry mouth and tongue, and loose skin.

Between 60% and 70% of infant deaths that are attributed to diarrhea, are caused by preventable dehydration (Chapman 1991:193). A Health Action International report summarizes the problem: "A great many infants suffering from diarrhea do not die from the disease but from mismanagement -- and the principal cause of death is dehydration"(Chetley 1993:28).

### **Diarrhea and Oral Rehydration Therapy**

In general, medications are not necessary to treat the commonest forms of diarrhea. Instead, the World Health Organization recommends replacing electrolytes and maintaining hydration. In this context they suggest that oral rehydration therapy (ORT) should be introduced at the very first signs of watery diarrhea. Despite these recommendations, a large number of different medicines for diarrhea continue to be used all over the world, many of which are sold over-the-counter. In fact, studies indicate that the use of antidiarrheals are on the increase in the developing world (Chetley 1993:28-29).

According to Haffeejee (1995:15) the reasons why there is continuing demand for these inappropriate medicines is a lack of understanding regarding the best treatment for diarrhea, the popularity of curative medicines and the lucrative profits that these poorly regulated medicines yield compared to ORT solutions.

The situation in South Africa is no different from other parts of the world with the use of over-the-counter antidiarrheals being especially popular. An additional problem in

South Africa is the abuse of this group of over-the-counter antacids (*Muti Wenyoni*), for the prevention and treatment of infant diarrhea.

### ***Muti Wenyoni*: Discussion**

Arguments that women who are using *Muti Wenyoni* and Dutch Medicines are uneducated, have rural backgrounds or are traditional are disproved by the facts about this group of women. The women interviewed represent ordinary Soweto women with young children. They were young, unmarried, without permanent jobs, had mostly a high school education and grew up in Soweto. Most of the women were not particularly religious or influenced by “tribal” traditions.

The reasons for the use of *Muti Wenyoni* and Dutch medicines are complex and have to do with the metaphorical meaning and symbolic value of medicine, as well as the position of power, authority and status of bio-medicine. The most popular type of *Muti Wenyoni* used in Soweto<sup>11</sup> was *Muti Wenyoni Mixture* (currently sold as *Muti Wenyoni Antacid*). This *Muti Wenyoni Mixture* has the most detailed description of all the *Muti Wenyoni*'s on the outside of the container (Appendix D). The most serious problem is the misleading descriptions on the box. There is a huge discrepancy between the English and Afrikaans explanations written on two sides of the container, and the Zulu and Sotho explanations written on the other two sides. While the Afrikaans and English versions simply state that the medicine is an antacid for hyper acidity and flatulence, the impression given by the Zulu and Sotho instructions is that the medicine is a treatment for diarrhea

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<sup>11</sup>Different *Muti Wenyoni* brand names seems to have market niches in different parts of South Africa.

and a sunken fontanelle (*Wenyoni/Hlohoana*). These versions not only state that *Muti Wenyoni* will help for *Inyoni* but also describe how the "medicine" will help to remove green stools and dirt from the child's stomach, all part of the folk aetiology of *Inyoni*. The written indications create the impression that the medicine constitutes the only necessary treatment for diarrhea, and there is no mention on the container, the bottle or pamphlet that ORT is appropriate. There is also no mention of how long the medicine should be used before consulting a doctor if the condition persists.

According to my research, all the other *Muti Wenyoni*'s are "copies" of the original *Muti Wenyoni Mixture*. Descriptions on the boxes are brief, but there are always differences and discrepancies between the English/Afrikaans and African language versions. All the *Muti Wenyoni*'s are clearly intended for the "African market".

The active ingredients of all the *Muti Wenyoni*'s, (except *Intunga* which has been denied registration and is not sold any more) are apparently harmless if used as an antacid. The preservatives, i.e. alcohol and chloroform, are not strictly regulated at the moment and may pose a problem if consumed in large quantities. Most countries do not allow chloroform as a preservative. The biggest problem with the *Muti Wenyoni*'s is the way in which people use the medicines and their reasons for using it. It is also problematic that companies continue to manufacture medicine for the "African market" disguised as something else (in this case an antacid).

Premier Pharmaceutical Company Limited bought the pharmaceutical company that originally manufactured *Muti Wenyoni Mixture*. During 1995 the new company applied to the Medicines Control Council for registration of *Muti Wenyoni Mixture* under the new name of *Muti Wenyoni Antacid*. Registration was granted. Unaware of the meaning of the



descriptions in the African languages on the old bottle container, they changed the description and submitted a slightly changed cover where the content of all the languages used corresponded. Although the name now clearly states Antacid and the description of the medicine on the box has been changed, few people would notice since the color and the design of the box is exactly the same as before. At the time of my interviews with them nobody at the pharmaceutical company was aware of the meaning of the indigenous concept for the condition called *Inyoni*. They expressed willingness to work with the MCC if a strong enough case can be made against the manufacture and sale of all the *Muti Wenyonis*.

## CHAPTER 10

### CONCLUSION: IMPLICATIONS FOR COMMUNITY HEALTH AND HEALTH PROMOTION

Over the last thirty years, the extensive use of pharmaceutical products in the Third World has become an increasing concern for international health organizations. Consumer advocates and other concerned parties have detailed the problems with pharmaceuticals and concluded that the problems occur on different levels of the “product cycle”.

Firstly, there are manufacturers who sell thousands of unnecessary products, in addition to the essential ones. Unfortunately most of the world’s poorer populations do not have access to these essential drugs and waste their money on products that are of little use. Pharmaceutical companies also often promote their products, especially over-the-counter products, in problematic ways: aggressive promotion to vulnerable groups, for example, children’s medicines to the mothers of infants and children who do not always need it; over-promotion of the usefulness of certain kinds of products, for example, antidiarrheals and cough mixtures; preying on parents’ fears about the well-being of their children; exploiting indigenous health concepts and manufacture medicines to fit the indigenous ideas for example, *Muti Wenyoni* or *Izishlambezo*. There are worldwide calls for the industry to take more responsibility for the entire drug cycle, from decisions about what to manufacture to the end use of the product.

Secondly, governments often do not have strict controls over pharmaceutical products and/or do little to enforce existing regulations. Controlling potentially hazardous

pediatric medicines should be a top priority. Thirdly, health professionals should prescribe in a responsible way. They are often unaware of how and for what purpose consumers really use medicine and allow consumers pressure them into prescribing certain medications.

Lastly, there are the consumers, the group about which we know least. This group and their behavior, other than non-compliance, was neglected in research until the 1980s when anthropologists began to pay attention to the contexts in which people use pharmaceutical products. The main insights that emerged from the anthropological studies are the high status of pharmaceutical products and that people all over the world reinterpret these products to fit into local belief systems and then use the medicines accordingly. This process of reinterpretation and incorporation is known as the indigenisation of pharmaceutical products.

The two groups of medicines on which I focused in this dissertation are (a) Dutch medicines, an example of the reinterpretation and indigenisation of medicines, and (b) *Muti Wenyonj*, an example of the exploitation of indigenous beliefs by the pharmaceutical industry.

The promotion and sale of *Muti Wenyonj* are a continuous problem because on the one hand it is an exploitation of very old beliefs concerning the cause diarrhea and dehydration. On the other hand, by encouraging its use, ordinary people are offered very little hope of learning more about diarrhea and prevention of dehydration through oral rehydration therapy. This is especially true for the rural areas of South Africa.

The healing strategies people use are organized and justified by their explanations of illness. In this context diarrhea and the symptoms of dehydration and a sunken fontanelle, are often poorly understood by infant caregivers. If we are to successfully

promote oral rehydration therapy (ORT) and encourage the management of diarrhea at household level, it is important to understand the variety of lay beliefs regarding causation, prevention, and treatment of infant diarrhea.

Access to appropriate and effective health care is a fundamental human right. Yet the promotion of antacids (used as ineffective "anti-diarrheal" medicines) under the guise of a traditional African remedy, *Muti Wenyoni*, clearly illustrates how cultural beliefs are exploited to capitalize on the biggest cause of infant mortality within South Africa's most vulnerable communities. By promoting ineffective medicines manufacturers not only breach the guidelines governing the labeling and registration of medicines, but also undermine health promotion by re-enforcing inaccurate views of diarrheal aetiology. In the process they disempower caregivers from making informed decisions and discouraging families from taking control of their children's health care. For these reasons the manufacture and promotion of *Muti Wenyoni* constitute an infringement of children's right to health as enshrined in the South African constitution.

However, the solution to the problem is not to immediately pull all forms of *Muti Wenyoni* off the market. There is evidence from the literature that if a medicine is not available over-the-counter it will be acquired through illegal avenues (Hardon et al 1991). The answer is threefold: (a) the situation should be carefully analyzed; (b) consumers should be targeted by health promotion experts for modification of their drug-using behavior so that they understand the benefits of appropriate drugs and safe drug use and (c) the medicine ingredients or content should be changed by the manufacturers.

Not only is it necessary to alert health professionals about the way *Muti Wenyoni* is used but also to promote the idea of ORT as a treatment for diarrhea. Pharmacists and especially their shop assistants should be made aware of why people buy *Muti Wenyoni*

and use the opportunity to promote ORT. The companies manufacturing *Muti Wenyoni* should be convinced that it is unethical and shortsighted to promote an ineffective medicine for the cultural condition *Inyoni*. They could change the medicine to an ORT, put a health promotion message on the box and a patient friendly insert into the box.

Dutch medicines are an example of how people reinterpret medicines over time to become something the manufacturers never intended it to be. This process of indigenisation took place over a period of 200 years and involved adaptation to local conditions and borrowing of ideas across different South African cultures. Today the majority of African mothers who use Dutch medicines do so to protect their infants from serious infant illness (*inyoni/phugwana* and *kokwana*) and use it for stomach ailments and/or to put their babies to sleep.

The problem with using Dutch medicines for *inyoni* is similar to the arguments made against *Muti Wenyoni*. An additional problem is that none of the Dutch medicines are intended for continuous use and several of them clearly state that they should not be used for children under one year. Their high alcohol content, and ingredients such as opium tincture and valerian make them unsafe for oral ingestion and in fact, also unsafe for external application because the skin effectively absorbs the ingredients. Again, as is the case for *Muti Wenyoni*, the solution is not to take these medicines immediately off the market but to give parents enough information about the potential dangers of each medicine to enable them to make informed decisions about their use. Unfortunately the different manufacturers deny that they know how parents use the medicines and this makes it very difficult to include them in any health promotion effort.

The Department of National Health has started to take action against problematic over-the-counter medicines by for example regulating the amount of alcohol used in medicines and clamping down on misleading names. The information from this study should be valuable since the department is in the process of mounting a nationwide health promotion effort for the responsible use of medicines.

In summary: the continued manufacture, promotion, and sale of Dutch medicines and *Muti Wenyoni* have the following consequences:

- (i) They exploit cultural beliefs about the causation of childhood illnesses, specifically diarrhoea and often play on parents' concern for the health of their children.
- (ii) They foster reliance upon ineffectual and inappropriate medicine.
- (iii) They seriously impede children's right to health under the new South African constitution, young children being particularly vulnerable and dependent on their mothers.
- (iv) They impair efforts to promote the management of diarrhoea at the household level using oral rehydration therapy as the treatment-of-choice for diarrhoea, especially in areas with poor water quality and inadequate sanitation.
- (v) They are part of a process of indoctrination that will encourage children to rely on curative medicines rather than preventative activities for the rest of their lives.

A Health Action International publication highlights the long term effects of the promotion of excessive drug use: "The drug industry creates a highly profitable market by ensuring that children develop a habit of taking unnecessary medicine. Children may believe that drugs will solve many of life's problems and can suffer psychological and social consequences" (Chetley 1993).

The many over-the-counter medicines and the way that they are being promoted and used in South Africa requires urgent action from health professionals and the Department of National Health:

- (i) The use of inappropriate medicines represents a huge waste of scant resources.
- (ii) The continuous administration of Dutch medicines and antacids such as *Muti Wenyoni* may have potentially harmful effects on children.
- (iii) Advertising standards of pharmaceutical products need to be reviewed and strictly enforced.
- (iv) The Department of National Health ought to consider speeding up their introduction of "essential drugs" and discouraging the manufacture and distribution of unnecessary and potentially-damaging placebos.
- (vi) Underlying these principles is the idea that the pharmaceutical industry should be, or made to be, accountable to the users of their products.
- (vii) Better legislation is required to control the manufacture, labeling, and promotion of over-the-counter medicines, especially medicines aimed at the "African market".

A project like this inevitably generates many questions unanswered. Some potential future projects include:

- (i) Research on the long-term effects of the continuous use of Dutch Medicines and *Muti Wenyoni* on infants.
- (ii) Ethnographic studies on the kinds of over-the-counter medicines used in South Africa, for what purposes they are used and how people use them.
- (iii) Ethnographic studies on ordinary people's perceptions of the infant body, as well as perceptions of illnesses and treatments associated with infants.

- (iv) Health promotion strategies for South Africa to encourage responsible use of medicines, especially medicines for children.
- (v) Evaluation of the efficiency of the many over-the-counter products for children, especially the ones aimed at the "African market".
- (vi) Designing consumer friendly package inserts using lay terminology that could help users to make informed decisions about over-the-counter medicines.
- (vii) Potential ways to reformulate "African medicines" to ensure that they are harmless when people choose to use them for their children.



## APPENDIX A QUESTIONNAIRE

### INTERVIEWER:

Use the map of Soweto. Start at the point marked X for each chosen cluster. You have to go to every 5th yard until you have interviewed six women from each cluster.

Select the first yard next to the X on the left side of the street.

Select all the children of 1 year or younger who permanently live in this yard and write their names on the sheet named "How to choose the respondent". Follow the instructions on the sheet in order to select a person for the interview.

Write down the cluster and the yard number on the questionnaire.

If there are no children of 12 months or younger in the yard or if there are people who refuse to participate, move clockwise in the street and skip 4 yards. Try the 5th yard.

Request each woman's verbal permission to ask a few questions about herself and the child, as well as questions about the types of medicines she uses for the child. Please point out that her answers will remain confidential. Thank her for her time and cooperation.

### SECTION A

1. Study ID number: \_\_\_\_\_
  2. Cluster number: \_\_\_\_\_
  3. Yard number: \_\_\_\_\_
  4. Address: \_\_\_\_\_
  5. Name of interviewer: \_\_\_\_\_
  6. Date of interview: \_\_\_\_\_
  7. Comments by interviewer: \_\_\_\_\_
-

HOW TO CHOOSE THE RESPONDENT  
(Primary caretaker of a child 12 months or younger)

C

House number: \_\_\_\_\_

A  Names of the children 12 months or younger in descending sequence of age	B									
	1	2	3	4	5	6	7	8	9	10
1.	1	1	1	1	1	1	1	1	1	1
2.	2	2	1	1	2	1	1	2	1	2
3.	1	2	3	2	1	2	3	1	3	3
4.	3	1	2	4	1	4	3	2	1	2
5.	4	2	3	1	5	5	3	1	4	2
6.	2	5	4	6	6	3	1	4	2	5
7.	6	7	5	4	2	1	7	3	2	5
8.	7	1	4	6	5	3	2	8	1	7
9.	4	8	5	9	7	1	2	3	6	9
10.	8	10	1	6	7	5	3	9	4	2

## INTERVIEWER:

- List the names of the children 12 months or younger who are permanent members of the yard in column A, starting with the oldest and ending with the youngest. Only list children whose primary caretakers are present at the time of the interview.
- Draw a line under the name of the youngest child and extend it across the grid.
- Place the last digit of the house number in the block provided at C.
- Find the column of the same number (as the one you have written at C) in B.
- Draw a line vertically down this column until it meets the horizontal line you have drawn from column A.
- These lines will cross at a number. Whatever that number is, will show which child's primary caretaker you should interview. For example, if the lines cross at number 3 column 5 you will interview the primary caretaker of child number 1.

8. Child's date of birth: \_\_\_\_/\_\_\_\_/199\_\_ (Age: \_\_\_\_\_ months)

9. Child's sex: \_\_\_\_\_

10. Child's birth order: \_\_\_\_\_

11a) How many times has the mother been pregnant? \_\_\_\_\_

b) Number of live births: \_\_\_\_\_

c) Number of stillbirths: \_\_\_\_\_

d) Number of miscarriages/abortions: \_\_\_\_\_

e) Have any of her children died?

Age: \_\_\_\_\_ Reason: \_\_\_\_\_

Age: \_\_\_\_\_ Reason: \_\_\_\_\_

Age: \_\_\_\_\_ Reason: \_\_\_\_\_

12. Mother's date of birth: \_\_\_\_/\_\_\_\_/19\_\_ (Age: \_\_\_\_\_ years)

13. Mother's education (highest standard passed): \_\_\_\_\_

14. Is mother working now: \_\_\_\_\_

15. Mother's occupation: \_\_\_\_\_

16. Mother's income: R \_\_\_\_\_ p/m

17. Who provides the major financial support for the mother and her child/children?  
\_\_\_\_\_

18. Mother's marital status: \_\_\_\_\_

19. Length of residence in Soweto: \_\_\_\_\_ years

20. If the mother did not grow up in Soweto, where did she spend the first 10 years of her life: \_\_\_\_\_

21. Mother's first language: \_\_\_\_\_

22. Which cultural traditions most influence her family life? \_\_\_\_\_

23. What is the mother's religious affiliation? \_\_\_\_\_

## SECTION B

## INTERVIEWER:

Please ask the woman to identify the medicine/s from your suitcase that she uses or used for this child. Please write the name of each medicines down. Also, ask the woman to name or show you any medicine/s not mentioned by you that she uses/used for this child.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_
12. \_\_\_\_\_
13. \_\_\_\_\_
14. \_\_\_\_\_
15. \_\_\_\_\_
16. \_\_\_\_\_
17. \_\_\_\_\_
18. \_\_\_\_\_
19. \_\_\_\_\_

## SECTION C

**INTERVIEWER:**

Please complete questions 1 to 9 in Section C for each of the identified medicine/s or combination of medicines in Section B.

1. Name or names of medicines: \_\_\_\_\_

2. What condition is it used for? \_\_\_\_\_

3. Why will it help for this condition (what effects does it have)? \_\_\_\_\_

4. How often and when does she use it (daily use, as well as total duration)? \_\_\_\_\_

5. Describe how it is used (including how much is given at a time, the form it is given in, how it is given to the child): \_\_\_\_\_

6. Does she have to take any precautions with this medicine and does it have any side effects? \_\_\_\_\_

7. How did she come to know about this medicine? \_\_\_\_\_


8. Where does she obtain the medicine? \_\_\_\_\_


9. Comments: \_\_\_\_\_


APPENDIX B  
FIVE EXAMPLES OF COVERS OF DUTCH MEDICINES





Figure 1 Doepa











**Entressdruppels**

S1

**Entressdruppels**

**Applicant/Applicant**  
Lennon Limited  
7 Fawcough Road/weg 7  
Port Elizabeth  
6001

001390 060456

**Entressdruppels**

S1

**Entressdruppels**

**Vir die verligting van**  
**maagpyne en winde,**  
**sensuueagtigheid en**  
**slooptoosheid.**

**Like 5 ml bevat:**

Quininechloride	0.4125 ml
Vanillin-chloride	1.125 ml
Compound Jenever Tincture	2.25 ml
Aromatic Elixir	1.125 ml
Water (100%)	61.475 ml

**DOSE:**

**Children:** 20 tot 30 druppels (1.5 tot 2.0 ml) vier tot vyfkeer per dag, naek maek.

**Vir volwasse en ouerwogte:**

20 tot 30 druppels (1.5 tot 2.0 ml) elke halfuur naek enigiende tyd.

**Bewaar onder 25°C.**

**HOU BUITE REIK VAN KINDERS.**

20 ml

Kohler PE

3

**Entressdruppels**

S1

**Entressdruppels**

**For the relief of stomach**  
**pains and winds, nervous**  
**conditions and**  
**sleeplessness.**

**Each 5 ml contains:**

Quinine Chloride	0.4125 ml
Vanillin Chloride	1.125 ml
Compound Jenever Tincture	2.25 ml
Aromatic Tincture	1.125 ml
Water (100%)	61.475 ml

**DOSE:**

**Adults:** 20 to 30 drops (1.5 to 2.0 ml) four or five times a day, and at night.

**For weak and over-weight persons:**

20 to 30 drops (1.5 to 2.0 ml) every half hour until relieved.

**Store below 25°C.**

**KEEP OUT OF REACH OF CHILDREN.**

20 ml

O785A

O785A

**Entressdruppels**

S1

**Entressdruppels**

**Applicant/Applicant**  
Lennon Limited  
7 Fawcough Road/weg 7  
Port Elizabeth  
6001

001390 060456












Figure 2 Entressdruppels



Groen Amara  
Essens amara of






**Essens amara of  
Groen Amara**

Applicant/Applicant  
Lennon Limited  
7 Fairclough Road/-weg 7  
Port Elizabeth  
6001

6 001300 06054



Approversnummer E15-10 (oud 101 1989)

**Essens amara of  
Groen Amara**

**'n Effektiewe Ionikum  
wat eellus verbeter.**

Ela 5 ml bevat:  
Die alkoholiese  
ekstraksiewe van  
Kruis Cordul Benedict.....0,5 g  
Kwessie.....0,16 g


Plus  
Ethanol (100%).....45,00% v/v

**DOSIS:**  
Volwasse: 'n Halwe tot een  
(5 ml) medisyne-maat drie- tot  
viermaal daaglik, voor maaltye.  
Bewaar onder 25°C.  
Hou dit houer dig toe.  
**HOU SUITE BIEK VAN KINDERS.**

**20 ml**

KOHLER CAP  
P.E.

12



Approversnummer E15-10 (oud 101 1989)

**Essens amara of  
Groen Amara**

**An effective tonic  
which improves  
appetite.**

Each 5 ml contains:  
The alcoholic extractives of  
Kruis Cordul Benedict.....0,5 g  
Quassia.....0,16 g

Plus  
Ethanol (100%).....45,00% v/v

**DOSAGE:**  
Adults: Half to one (5 ml) medicine  
measure three to four times daily,  
before meals.  
Store below 25°C.  
Keep tightly closed.  
**KEEP OUT OF REACH OF CHILDREN.**

**20 ml**

● Q945A

● Q945A










Figure 3 Groen Amara





Haarlemensis  
(Haarlemmer olie)  
R 3--72  
TAP MM

**Haarlemensis**  
(Haarlemmer olie)

Applicant: Applicant  
Lennon Limited  
7 Fairclough Road/weg 7  
Port Elizabeth  
6001

6



001390 060531

**Haarlemensis**  
(Haarlemmer olie)

Vir die behandeling  
van nier- en blaas-  
kwale.

Elke 5 ml bevat:

Balsam	1,730 ml
Sulphurisbasis	2,015 ml
Argolisie	0,163 g
Terpenhynale	1,250 ml

POSIS:  
Neem 15 druppels (1 ml) in melk  
of wyn met sloegtyd.  
Bewaar onder 25°C.

HOU BUITE BEREIK VAN KINDERS.


20 ml

KOHLER CAP  
P.E.  
1  
7

**Haarlemensis**  
(Haarlemmer olie)

Applicant: Applicant  
Lennon Limited  
7 Fairclough Road/weg 7  
Port Elizabeth  
6001

6



001390 060531

**Haarlemensis**  
(Haarlemmer olie)

For the treatment of  
kidney and bladder  
complaints.

Each 5 ml contains:

Balsam	1,730 ml
Sulphurisbasis	2,015 ml
Argolisie	0,163 g
Terpenhynale	1,250 ml

POSIS:  
Take 15 drops (1 ml) in milk or  
wine at bedtime.  
Store below 25°C.

KEEP OUT OF REACH OF CHILDREN.

20 ml

• H027A  
• H027A




Figure 4 Haarlemensis

  
 Stuijdruppels  
(Saamgestelde)  
 R 6-847  
 11AP PM










**Stuijdruppels**  
(Saamgestelde)

Applicator/Appelhaas  
Lennon Limited  
7 Fairclough Road - weg 7  
Port Elizabeth  
6001

2860900060602



**Stuijdruppels**  
(Saamgestelde)

Aanbevelingsnummer E1535 (Med 101/1985)

**Vir die verligting van  
winderigheid; krampe  
en koliek.**

Elke 5 ml bevat:

Valerianekruidt.....	1,136 ml
Kamfer.....	0,00015 ml
Neutolie.....	0,00075 ml
Rosmarynolie.....	0,0001 ml
Levensleide (Spil).....	0,007 ml
Duvelledekruidt.....	1,134 ml
Oplosbare Ether.....	0,398 ml
Ethanol (100%).....	56,38% v/v

**DOSIS:**  
Volwasseesee: 5 tot 10 ml (1 tot 2  
medisynermedie) wanneer nodig.  
Bewaar onder 25°C.  
Hou dig toe.

**HOU BUITE BEREIK VAN KINDERS.**

20 ml

KOHLEK C&P  
P.E.  
1 3

**Stuijdruppels**  
(Saamgestelde)

Applicator Number E1535 (Ap 101/1985)



20 ml

**Stuijdruppels**  
(Saamgestelde)

Applicator Number E1535 (Ap 101/1985)

**For the relief of  
flatulence; gripes and  
colic.**

Each 5 ml contains:

Tincture Valerian.....	1,136 ml
Cassia Oil.....	0,00015 ml
Nutmeg Oil.....	0,00075 ml
Rosemary Oil.....	0,0001 ml
Spice Lemon Oil.....	0,007 ml
Tincture of Aniseeds.....	1,134 ml
Solvent Ether.....	0,398 ml
Ethanol (100%).....	56,38% v/v

**DOSAGE:**  
Adults: 5 to 10 ml (1 to 2 medicine  
measures) when required.  
Store below 25°C.  
Keep tightly closed.

**KEEP OUT OF REACH OF CHILDREN.**

20 ml

● H032A  
● H032A



Figure 5 Stuijdruppels

APPENDIX C  
PACKAGE INSERTS OF DUTCH MEDICINES

**BALSEM-KOPIVA (Drops)**

**SCHEDULING STATUS:** Not scheduled.

**PROPRIETARY NAME:** BALSEM-KOPIVA (Drops)

**COMPOSITION:** Balsem Copaiba B.P.C. 1949.

**PHARMACOLOGICAL CLASSIFICATION:** A 18.5 Urinary tract antiseptics.

**PHARMACOLOGICAL ACTION:** Balsem-Kopiva is carminative and is said to possess mild urinary antiseptic properties.

**INDICATIONS:** Balsem-Kopiva is used as a household remedy for the treatment of mild kidney ailments, backache and inflammation of the bladder.

**CONTRA-INDICATIONS:** Sensitivity to the product.

**DOSAGE AND DIRECTIONS FOR USE:**

10 to 30 drops (0.5-2.0 ml) on sugar, or in milk three times a day.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

In some patients it may produce a morbilliform rash and its continued use tends to cause digestive disturbances.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

See "Side-effects and Special Precautions". Use thereof must be discontinued.

**IDENTIFICATION:** Viscous yellow to golden brown transparent liquid with a characteristic odour.

**PRESENTATION:** Bottles of 20 ml.

**STORAGE INSTRUCTIONS:**

Store below 25°C.

**KEEP OUT OF REACH OF CHILDREN.**

**APPLICATION NUMBER:** H1632 (Act/Wet 101/1965).

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

Port Elizabeth 6001

**Date of publication of this package insert:** 4.4.1985.

**BEHOEDMIDDEL VIR KINDERS****SCHEDULING STATUS:** **Unscheduled.****PROPRIETARY NAME:** **BEHOEDMIDDEL VIR KINDERS (Suspension)****COMPOSITION:**

Each 5 ml contains:

Light Magnesium Carbonate	210.00 mg
Prepared Chalk	79.85 mg
Aniseed Spirit	0.40 ml
Ethanol (100%)	6.48% v/v

**PHARMACOLOGICAL CLASSIFICATION:** A 11.4.1: Medicines acting on gastro-intestinal tract: Acid neutralisers.**PHARMACOLOGICAL ACTION:** Antacid and carminative.**INDICATIONS:** The aniseed spirit has a carminative action and helps relieve flatulence, gastric discomfort and colic. The prepared chalk and magnesium carbonate are used as antacids. Prepared chalk may have a constipating effect and the preparation may thus be used for diarrhoea. This constipating effect is however reduced by the magnesium carbonate.**CONTRA-INDICATIONS:** Patients with impaired renal function.**DOSAGE AND DIRECTIONS FOR USE:****SHAKE THE BOTTLE.****For windiness, cramps and colic:****Babies Under 1 month** - 5 to 15 drops (1/3 - 1 ml).**1 to 3 months** - 15 to 30 drops (1 - 2 ml).**Over 3 months** - 30 drops (2 ml) three times daily after meals.

Repeat dosage after 1 hour if necessary.

**For diarrhoea:****Babies Under 1 month** - 1 medicine measureful (5 ml) for 3 doses.**1 to 3 months** - 1½ medicine measureful (7.5 ml) for 3 doses.**Over 3 months** - 2 medicine measureful (10 ml) for 3 doses.**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

Large doses may cause constipation. Hypercalcaemia as well as alkalosis can occur following regular use.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

None.

**IDENTIFICATION:** An off-white suspension with a sweet taste and aniseed odour.**PRESENTATION:** Bottles of 20 ml.**STORAGE INSTRUCTIONS:**

Store below 25°C in a tightly closed container.

**KEEP OUT OF REACH OF CHILDREN.****APPLICATION NUMBER:** E1528 (Act/Wet 101/1965).**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

PORT ELIZABETH

6001

**Date of publication of this package insert:** 4.4.1985

**BORSDRUPPELS**

**SCHEDULING STATUS:** Unscheduled.

**PROPRIETARY NAME:** BORSDRUPPELS

**COMPOSITION:**

Each 5 ml contains:

Liquorice extract	1.125 g
Fennel Oil	0.003 ml
Aniseed Oil	0.009 ml
Ethanol (100%)	13.50% v/v

**PHARMACOLOGICAL CLASSIFICATION:** A 10.1 Antitussives and expectorants.

**PHARMACOLOGICAL ACTION:** Borsdruppels has demulcent and expectorant properties. Its demulcent action protects the surfaces of the pharynx from irritation and so reduces the frequency of coughing. Its expectorant action produces an increase in the secretions of the respiratory tract and so reduces the viscosity of the mucous, thereby inducing a productive cough which is less painful to the patient.

**INDICATIONS:** Borsdruppels provides a symptomatic relief from cough, croup and bronchitis.

**CONTRA-INDICATIONS:** Borsdruppels should not be administered to patients suffering from hypertension.

**DOSAGE AND DIRECTIONS FOR USE:**

**Adults:** One to two (5 ml) medicine measures.

**Children:** 1.0-1.5 ml (15 to 20 drops).

Three times a day, in water, tea or honey.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

Borsdruppels in large doses may cause sodium retention and potassium loss leading to hypertension, water retention and electrolyte imbalance.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

See "Side-effects and Special Precautions". The use of the medicine should be discontinued.

**IDENTIFICATION:** Dark brown, cloudy liquid with the odour of anise.

**PRESENTATION:** Bottles of 20 ml.

**STORAGE INSTRUCTIONS:**

Store below 25°C, and keep container tightly closed.

**KEEP OUT OF REACH OF CHILDREN.**

**APPLICATION NUMBER:** G543 (Act 101/1965)

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

Port Elizabeth 6001

**Date of publication of this package insert:** 4.4.1985.

**DUIWELSDREKDRUPPELS**

**SCHEDULING STATUS:** Not scheduled.

**PROPRIETARY NAME:** DUIWELSDREKDRUPPELS

**COMPOSITION:**

Each 5 ml contains:

Asafoetida	1 g
Ethanol (96%)	62.50% v/v

**PHARMACOLOGICAL CLASSIFICATION:**

11.4.3 Medicines acting on gastro-intestinal tract (other).

**PHARMACOLOGICAL ACTION:**

Carminative and expectorant.

**INDICATIONS:**

Duiwelsdrekdrupeles relieves the stomach of excessive amounts of air or gases which normally would cause the uncomfortable distended feeling. Its expectorant action is useful in the treatment of dry coughs associated with bronchitis.

**CONTRA-INDICATIONS:** Sensitivity to the product.

**DOSAGE AND DIRECTIONS FOR USE:**

2 to 4 ml (30 to 60 drops) three or four times a day, with sugar or honey.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

None known.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

None known.

**IDENTIFICATION:**

Light brown, clear liquid with a foul odour and taste.

**PRESENTATION:** 20 ml bottles.

**STORAGE INSTRUCTIONS:**

KEEP OUT OF THE REACH OF CHILDREN

Keep container tightly closed

Store below 25°C

**APPLICATION NUMBER:** B1210 (Act 101/1965)

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

PORT ELIZABETH

6001

**Date of publication of this package insert:** 4.4.1985

**ENTRESS-DRUPELS****SCHEDULING STATUS: S1****PROPRIETARY NAME: ENTRESS-DRUPPELS****COMPOSITION:**

Each 5 ml contains:

Opium tincture	0.4125 ml
Valerian tincture	1.125 ml
Compound lavender tincture	2.25 ml
Asafoetida tincture	1.125 ml
Contains ethanol (100%)	61.67% v/v

**PHARMACOLOGICAL CLASSIFICATION:**

A 2.2: Central Nervous System Depressants: sedatives, hypnotics.

**PHARMACOLOGICAL ACTION:**

The volatile principles of valerian, lavender and asafoetida exert a carminative action which relieves winds and stomach pains while the analgesic property of opium soothes and relaxes the intestinal muscles. Valerian has been used for nervous conditions, the calming effect of which is enhanced by the opium tincture which promotes restful sleep.

**INDICATIONS:** For the relief of stomach pains and winds, nervous conditions and sleeplessness.

**CONTRA-INDICATIONS:** Respiratory depression, asthma. Should not be given to patients being treated with tricyclic antidepressants, phenothiazines and mono-amine oxidase inhibitors.

**DOSAGE AND DIRECTIONS FOR USE:**

NOT TO BE USED BY CHILDREN UNDER 2 YEARS.

**Adults**

20 to 30 drops (1.5-2 ml) four or five times a day and at night.

For winds and stomach pains

20 to 30 drops (1.5-2 ml) every half an hour until relieved.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

Large doses may give rise to nausea and vomiting, constipation and miosis.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Effects of overdosage may include nausea and vomiting and respiratory depression. The stomach should be emptied by aspiration and lavage and a saline purgative should be given.

**IDENTIFICATION:** A reddish-brown bright liquid with a strong odour of asafoetida.**PRESENTATION:** Bottles of 20 ml.**STORAGE INSTRUCTIONS:**

Store below 25°C.

KEEP OUT OF REACH OF CHILDREN.

**APPLICATION NUMBER:** B1204 (Act/Wet 101/1965)**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

PORT ELIZABETH

6001

**Date of publication of this package insert:** 4.4.1985.

**ESSENS AMARA OF GROEN AMARA**

**SCHEDULING STATUS:** Unscheduled.

**PROPRIETARY NAME:** ESSENS AMARA OF GROEN AMARA

**COMPOSITION:**

Each 5 ml contains:

The alcoholic extractives of

Herb Cardui Benedict	0.5 g
Quassia	0.16 g
Ethanol (100%)	45.00% v/v

**PHARMACOLOGICAL CLASSIFICATION:** A 11.1 Digestants.

**PHARMACOLOGICAL ACTION:** Stomachic bitter.

**INDICATIONS:**

Essens Amara of Groen Amara is an effective tonic which improves appetite.

**CONTRA-INDICATIONS:**

Patients with gastric and duodenal ulcers.

**DOSAGE AND DIRECTIONS FOR USE:**

Adults: Half to one (5 ml) medicine measure three to four times daily before meals.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

None known when used as directed.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

See "Side-effects and Special Precautions".

**IDENTIFICATION:**

A bright green liquid with a vegetable odour.

**PRESENTATION:** Bottles of 20 ml.

**STORAGE INSTRUCTIONS:**

Store below 25°C.

Keep container tightly closed.

KEEP OUT OF REACH OF CHILDREN.

**APPLICATION NUMBER:** E1510 (Act/Wet 101/1965).

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

PORT ELIZABETH

6001

**Date of publication of this package insert:** 4.4.1985.



**HAARLEMENSIS (DROPS)****SCHEDULING STATUS:** Unscheduled**PROPRIETARY NAME:** HAARLEMENSIS**COMPOSITION:**

Each 5 ml contains:

Balsam Sulphuris Base	1.730 ml
Arachis Oil	2.015 ml
Tar	0.163 g
Turpentine Oil	1.250 ml

**PHARMACOLOGICAL CLASSIFICATION:** A 11.5 Laxatives.**PHARMACOLOGICAL ACTION:**

The precipitated sulphur in the balsam sulphuris base has a mild laxative action and the tar has an expectorant action.

**INDICATIONS:**

For the treatment of kidney and bladder complaints.

**CONTRA-INDICATIONS:**

Sensitivity to any of the active ingredients.

**DOSAGE AND DIRECTIONS FOR USE:**

15 drops (1 ml) in milk or wine at bedtime.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

Sensitivity reactions may occur. Use of the product should be discontinued.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Excessive doses may cause gastrointestinal irritation, nausea, vomiting and diarrhoea. Excitement and convulsions or stupor and respiratory failure may occur. In acute poisoning the stomach should be emptied by aspiration and lavage. A saline purgative (30 g sodium sulphate in 250 ml water) can be given unless catharsis is already present. Demulcent drinks may be given. Large volumes of fluid should be given, provided renal function is adequate.

**IDENTIFICATION:**

Dark brown liquid.

**PRESENTATION:** 20 ml Packs.

**STORAGE INSTRUCTIONS:**

KEEP OUT OF REACH OF CHILDREN

Store below 25°C

**APPLICATION NUMBER:** H1625 (Act/Wet 101/1965).

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited  
7 Fairclough Road  
Port Elizabeth  
6001

**Date of publication of this package insert:** 4.4.1985.

**JAMAICA GINGER (Solution)**

**SCHEDULING STATUS:** Unscheduled

**PROPRIETARY NAME:** JAMAICA GINGER (Solution)

**COMPOSITION:**

Each ml contains the alcoholic extractives of:

Ginger	0.5 g
Ethanol(100%)	87.30% v/v

**PHARMACOLOGICAL CLASSIFICATION:**

A 11.2 Gastro-intestinal antispasmodics and cholinolytics (anti-cholinergics).

**PHARMACOLOGICAL ACTION:**

Carminative.

**INDICATIONS:**

Jamaica Ginger is indicated for use in the treatment of colic, winds, pains in the stomach and indigestion.

**DOSAGE AND DIRECTIONS FOR USE:**

Five to ten drops (0.5 to 1.0 ml) in a little water three or four times a day.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

Large doses of the product may produce gastro-intestinal irritation, nausea, vomiting and diarrhoea. There may be occasional irritation of the urinary tract and aggravation of pre-existing inflammatory conditions.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

The central nervous system may either be depressed, leading to respiratory failure and stupor, or stimulated, leading to excitement and convulsions. In acute poisoning, the stomach should be emptied by aspiration and lavage. A saline purgative such as sodium sulphate (30 g in 250 ml water) can be given, unless catharsis is already present. Demulcent drinks may be given. Large volumes of fluid should be given provided renal function is adequate.

**IDENTIFICATION:**

Light brown, bright liquid with the characteristic odour of ginger.

**PRESENTATION:** Bottles of 20 ml.

**STORAGE INSTRUCTIONS:**

Store below 25°C.

Keep container tightly closed.

KEEP OUT OF REACH OF CHILDREN.

**APPLICATION NUMBER:** E 1953 (Act/Wet 101/1965).

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited  
7 Fairclough Road  
Port Elizabeth  
6001

**Date of publication of this package insert:** 4.4.1985.

**KRAMPDRUPPELS****SCHEDULING STATUS:** S1**PROPRIETARY NAME:** KRAMPDRUPPELS**COMPOSITION:** Each 5 ml contains:

Opium Tincture	0.165 ml
Valerian Tincture	2.248 ml
Compound Lavender Tincture	0.375 ml
Ether	0.617 ml
Ethanol (100%)	61.44% v/v

**PHARMACOLOGICAL CLASSIFICATION:** A 2.7 Narcotic analgesics.**PHARMACOLOGICAL ACTION:** Krampdruppels has analgesic, carminative and central nervous system depressant actions.**INDICATIONS:** Krampdruppels is indicated in the treatment of diarrhoea, colic, and cramps. It is very useful in relieving flatulence or gas accumulation in the gastro-intestinal tract.**CONTRA-INDICATIONS:** It is contra-indicated in respiratory depression, especially in the presence of cyanosis and excessive bronchial secretions. It is also contra-indicated in the presence of acute alcoholism, delirium tremens and convulsive disorders. It should not be given during an attack of bronchial asthma or in heart failure secondary to chronic lung disease. It should be given with caution to patients with hypothyroidism, adrenocortical insufficiency, impaired liver function, prostatic hypertrophy, or shock.**DOSAGE AND DIRECTIONS FOR USE:** SHOULD NOT BE USED FOR CHILDREN UNDER 2 YEARS.**Adults:** For pains and cramps, half a medicine measure (30 drops) every 15 to 30 minutes until relief is obtained. **Children:** Half the adult dose.**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:** In some instances nausea, vomiting, constipation, dry mouth, sedation, restlessness or changes of mood may occur in hypersensitive patients. Habitual use may lead to drug dependence of the morphine type.**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Coma, pinpoint pupils, depressed respiration and cyanosis, fall in body temperature and flaccid skeletal muscles. The stomach should be emptied by aspiration and lavage; a 0.02% aqueous solution of potassium permanganate may be employed. A saline purgative such as sodium sulphate, 30g in 250 ml water, should be given to aid peristalsis. Naloxone hydrochloride 400 µg is given subcutaneously, intra-muscularly, or intravenously, repeated at intervals of 2 or 3 minutes if necessary. In children, a dose of 5-10 µg per kg body weight may be given, while in neonates a dose of 10 µg per kg body weight may be given.

**IDENTIFICATION:** A bright, brown liquid with an ethereal odour.**PRESENTATION:** 20 ml bottles.**STORAGE INSTRUCTIONS:****KEEP OUT OF REACH OF CHILDREN**

Keep container tightly closed. Store below 25°C

**APPLICATION NUMBER:** B1195 (Act/Wet 101/1965).**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road, Port Elizabeth 6001

**Date of publication of this package insert:** 4.4.1985.

**PARAGORIESE-ELIKSER****SCHEDULING STATUS:** S2**PROPRIETARY NAME:** PARAGORIESE-ELIKSER**COMPOSITION:** Each 5 ml contains:

Opium Tincture	0.25 ml
Aniseed Oil	0.015 ml
Camphor	14.97 mg
Benzoic Acid	24.95 mg
Ethanol (100%)	58.5% v/v

**PHARMACOLOGICAL CLASSIFICATION:** A 2.7 Narcotic Analgesics.

**PHARMACOLOGICAL ACTION:** Paragoriese-Elikser in addition to having analgesic and narcotic actions has central stimulant actions. It depresses the thalamus, sensory cortex, and respiratory and cough centres. It increases tone in involuntary muscle, especially the sphincters of the gastro-intestinal tract.

**INDICATIONS:** The principal use of Paragoriese-Elikser is for the treatment of diarrhoea, abdominal pain and for the treatment of cough.

**CONTRA-INDICATIONS:** It is contra-indicated in respiratory depression, especially in the presence of cyanosis and excessive bronchial secretion. It is also contra-indicated in the presence of acute alcoholism, delirium tremens and convulsive disorders. It should not be given during an attack of bronchial asthma or in heart failure secondary to chronic lung disease. It should be given with caution to patients with hypothyroidism, adrenocortical insufficiency, impaired liver function, prostatic hypertrophy, or shock.

**DOSAGE AND DIRECTIONS FOR USE:****NOT TO BE USED FOR CHILDREN UNDER 2 YEARS.****Adults:** One to two medicine measures (5-10 ml) up to four times daily.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:** The commonest are nausea, loss of appetite, constipation, confusion and sweating. Dry mouth, facial flushing, vertigo, bradycardia, palpitations, faintness, sedation, restlessness and changes of mood. Habitual use may lead to drug dependence of the morphine type.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Coma, pinpoint pupils, depressed respiration and cyanosis, fall in body temperature and flaccid skeletal muscles. The stomach should be emptied by aspiration and lavage: a 0.02% aqueous solution of potassium permanganate may be employed. A saline purgative such as sodium sulphate, 30 g in 250 ml water, should be given to aid peristalsis. Intensive supportive therapy may be necessary to correct respiratory failure and shock. In addition, the specific antagonist naloxone hydrochloride is used to counteract very rapidly the severe respiratory depression and coma produced by excessive doses of narcotic analgesics. Naloxone hydrochloride 400 µg is given subcutaneously, intramuscularly, or intravenously, repeated at intervals of 2 or 3 minutes if necessary. In children, a dose of 5-10 µg per kg body weight may be given, while in neonates a dose of 10 µg per kg body weight may be given.

**IDENTIFICATION:** A bright, brown liquid with the odour of camphor.**PRESENTATION:** Bottles of 20 ml.**STORAGE INSTRUCTIONS:** Store below 25°C. Keep container tightly closed**KEEP OUT OF REACH OF CHILDREN****APPLICATION NUMBER:** B888 (Act/Wet 101/1965).**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited  
7 Fairclough Road  
Port Elizabeth 6001

**Date of publication of this package insert:** 4.4.1985.

**ROOILAVENTAL (SOLUTION)****SCHEDULING STATUS:** Not scheduled**PROPRIETARY NAME:** ROOILAVENTAL (Solution)**COMPOSITION:**

Each 5 ml contains:

The alcoholic extractives of:

Nutmeg	50mg
Cinnamon Bark	50 mg
Red Sanders Wood	100 mg
plus	
Rosemary Oil	0.0025 ml
Lavender Oil	0.025 ml
Ethanol (100%)	90.00% v/v

**PHARMACOLOGICAL CLASSIFICATION:**

A 11.2: Gastro-intestinal antispasmodics and cholinolytics (anti-cholinergics).

**PHARMACOLOGICAL ACTION:**

The drug is a carminative and is believed to exert some antispasmodic action on the stomach and intestinal muscles.

**INDICATIONS:**

Rooilavalent is effective in the treatment of winds, indigestion and associated stomach aches.

**CONTRA-INDICATIONS:** Patients with renal and hepatic malfunction.**DOSAGE AND DIRECTIONS FOR USE:****Adults:** One (5 ml) medicine measure in water every half an hour until relief is obtained.**Children:** 10 drops (0.5 ml) in a little sweetened water, when necessary.**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:** None known, if taken as directed.**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Excessive doses of the drug produce gastro-intestinal irritation and nausea.

**IDENTIFICATION:**

Red, bright liquid with the characteristic odour of cinnamon.

**PRESENTATION:** 20 ml Packs.**STORAGE INSTRUCTIONS:**

Store below 25°C

Keep container tightly closed

KEEP OUT OF THE REACH OF CHILDREN

**APPLICATION NUMBER:** E1951 (Act 101/1965).**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

Port Elizabeth

6001

**Date of publication of this package insert:** 4.4.1985.

**STAALDRUPPELS**

**SCHEDULING STATUS:** Unscheduled.

**PROPRIETARY NAME:** STAALDRUPPELS

**COMPOSITION:**

Each 20 ml contains 3.00 g ferric chloride.

**PHARMACOLOGICAL CLASSIFICATION:** A 8.3 Erythropoietics.

**PHARMACOLOGICAL ACTION:**

Erythropoietic and styptic.

**INDICATIONS:**

Staaldruppels may be used for iron-deficiency anaemias. It is also effective in stopping bleeding resulting from minor cuts and wounds.

**CONTRA-INDICATIONS:**

Patients with abdominal ailments, haemochromatosis and those suffering from liver damage.

**WARNING:**

This product diminishes the absorption of tetracyclines when given concomitantly.

**DOSAGE AND DIRECTIONS FOR USE:**

10-15 drops (1.0 ml) in a wineglassful of water three times daily.

As a styptic for cuts and wounds: Apply a few drops over the wound.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

These are usually rare and if they do occur they may take the form of gastro-intestinal discomfort, diarrhoea and vomiting.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Induce emesis, followed by gastric lavage with a 1% solution of sodium bicarbonate.

**IDENTIFICATION:**

Clear, yellowish-brown solution.

**PRESENTATION:** Bottles of 20 ml.

**STORAGE INSTRUCTIONS:**

Store below 25°C.

Keep container tightly closed.

KEEP OUT OF REACH OF CHILDREN.

**APPLICATION NUMBER:** H836 (Act/Wet 101/1965).

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

Port Elizabeth

6001

**Date of publication of this package insert:** 4.4.1985

**STUIPDRUPPELS (Saamgestelde)****SCHEDULING STATUS:** Not scheduled**PROPRIETARY NAME:** STUIPDRUPPELS (Saamgestelde)**COMPOSITION:**

Each 5 ml contains:

Tincture Valerian	1.136 ml
Cassia Oil	0.00015 ml
Nutmeg Oil	0.00075 ml
Rosemary Oil	0.0001 ml
Spike Lavender Oil	0.007 ml
Tincture of Asafoetida	1.134 ml
Solvent Ether	0.398 ml
Ethanol (100%)	56.38% v/v

**PHARMACOLOGICAL CLASSIFICATION:**

A 11.2 Gastro-intestinal Antispasmodics and Cholinolytics.

**PHARMACOLOGICAL ACTION:**

Carminative.

**INDICATIONS:**

Flatulence, gripes and colic.

**CONTRA-INDICATIONS:**

Patients with renal and hepatic malfunctions.

**DOSAGE AND DIRECTIONS FOR USE:****Adults:** 5-10 ml (1-2 medicine measures) when required.**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

None known, if taken as prescribed.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Excessive doses of the drug produce gastro-intestinal irritation and nausea.

**IDENTIFICATION:**

A bright, reddish-brown liquid.

**PRESENTATION:** Packs of 20 ml.**STORAGE INSTRUCTIONS:**

Store below 25°C.

Keep tightly closed.

**KEEP OUT OF REACH OF CHILDREN.****APPLICATION NUMBER:** E1535 (Act 101/1965).**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

PORT ELIZABETH

6001

**Date of publication of this package insert:** 4.4.1985.

**TURLINGTON (TINCTURE)****SCHEDULING STATUS:** Unscheduled.**PROPRIETARY NAME:** TURLINGTON (Tincture)**COMPOSITION:**

Each 5 ml contains the alcoholic extractives of:

Benzoin	0.500 g
Prepared Storax	0.375 g
Tolu Balsam	0.125 g
Aloes	0.100 g
Ethanol(100%)	76.06% v/v

**PHARMACOLOGICAL CLASSIFICATION:** A 10.2.1 Inhalants.**PHARMACOLOGICAL ACTION:**

Turlington is used as a stimulant expectorant due to the action of benzoin, tolu balsam and storax. Turlington exercises antiseptic and styptic properties when applied to the skin.

**INDICATIONS:**

Symptomatic treatment of coughs and chronic bronchitis. As an antiseptic styptic when applied undiluted to small cuts and scratches.

**DOSAGE AND DIRECTIONS FOR USE:****As an expectorant**

Half to one medicine measure (2.5-5 ml) two or three times daily. Since Turlington cannot be mixed with other liquids, it is usually taken with sugar or egg yolk.

**As a styptic**

Apply a few drops to the cut or wound.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

May occasionally cause dermatitis.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

See "Side-effects and Special Precautions".

**IDENTIFICATION:**

Dark brown liquid.

**PRESENTATION:** Bottles of 20 ml.

**STORAGE INSTRUCTIONS:**

Store below 25°C

**KEEP OUT OF THE REACH OF CHILDREN**

**APPLICATION NUMBER:** G540 (Act 101/1965).

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited  
7 Fairclough Road  
Port Elizabeth  
6001

**Date of publication of this package insert:** 4.4.1985.



**VERSTERKDRUPPELS****SCHEDULING STATUS:** Unscheduled**PROPRIETARY NAME:** VERSTERKDRUPPELS**COMPOSITION:**

Each 5 ml contains:

The alcoholic extractives of:

Cinchona Bark	85.0 mg
Gentian	25.0 mg
Dried Bitter Orange Peel	107.1 mg
Quassia	85.0 mg
Ethanol(100%)	45.00% v/v

**PHARMACOLOGICAL CLASSIFICATION:**

A 11.1 Medicines acting on gastro-intestinal tract (Digestants).

**PHARMACOLOGICAL ACTION:**

Cinchona, Gentian and Quassia are bitters. They act on the taste receptors causing reflex stimulation of gastric secretion and are believed to improve the appetite.

**INDICATIONS:**

Versterkdruppels is an excellent tonic preparation that restores vitality and appetite caused by indigestion.

**CONTRA-INDICATIONS:**

Patients with gastric and duodenal ulcers.

**DOSAGE AND DIRECTIONS FOR USE:**

Half to one medicine measure (5 ml) three times a day in water.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

These are relatively rare but large doses may produce nausea, vomiting, headache and skin rash.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

See "Side-effects and Special Precautions". Treatment is symptomatic.

**IDENTIFICATION:**

A bright reddish-brown liquid with a characteristic odour and taste.

**PRESENTATION:** Bottles of 20 ml.**STORAGE INSTRUCTIONS:**

Store below 25°C

Keep container tightly closed

**KEEP OUT OF THE REACH OF CHILDREN****APPLICQTION NUMBER:** E1525 (Act/Wet 101/1965).**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

PORT ELIZABETH

6001

**Date of publication of this package insert:** 4.4.1985.

**WITDULSIES**

**SCHEDULING STATUS:** Unscheduled.

**PROPRIETARY NAME:** WITDULSIES

**COMPOSITION:**

Each 5 ml contains:

Ethyl nitrite	93.75 mg
Ethanol (100%)	42.60% v/v

**PHARMACOLOGICAL CLASSIFICATION:** A 2.8 Non-narcotic analgesics, antipyretics.  
**PHARMACOLOGICAL ACTION:**

Witdulsies has proved to be a very useful diaphoretic acting as an effective sweating agent in chills. It reduces the temperature most successfully in feverish conditions by inducing vasodilation.

**INDICATIONS:**

Witdulsies is an ideal preparation for the treatment of colds and fever. It may be used for the treatment of mild asthma attacks and dizziness.

**CONTRA-INDICATIONS:**

Patients with closed-angle glaucoma.

**DOSAGE AND DIRECTIONS FOR USE:**

**Adults**

**For colds:** Take half a medicine measure (2.5 ml) in a wineglassful of water three times a day.

**For asthma and dizziness:** Take one (5 ml) medicine measure in a wineglassful of water.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

Large doses may cause flushing of the face, fainting, severe headache, throbbing in the head, nausea and vomiting. Witdulsies should be used with caution in patients with marked anaemia, cerebral haemorrhage or coronary thrombosis.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Fainting should be treated by keeping the patient in a reclining position with the head lowered.

Methaemoglobinaemia has been reported in infants. In the instances of severe toxicity contact a doctor immediately.

**IDENTIFICATION:**

Clear, bright, faintly yellow liquid.

**PRESENTATION:** Packs of 20 ml.

**STORAGE INSTRUCTIONS:**

Store below 25°C in a well-closed container.

**KEEP OUT OF REACH OF CHILDREN.**

**APPLICATION NUMBER:** B1183 (Act/Wet 101/1965).

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited  
7 Fairclough Road  
Port Elizabeth  
6001

**Date of publication of this package insert:** 4.4.1985.

**WONDERKROONESSENS****SCHEDULING STATUS:** Unscheduled.**PROPRIETARY NAME:** WONDERKROONESSENS**COMPOSITION:**

Each 5 ml contains:

The alcoholic extractives of

Rhubarb	45.0 mg
Gentian	22.5 mg
Valerian	22.5 mg
African Ginger	22.5 mg
Inula	17.5 mg
plus	
Cape Aloes	162.5 mg
Camphor	10.0 mg
Potassium Carbonate	22.5 mg
Ethanol (100%)	45.00% v/v

**PHARMACOLOGICAL CLASSIFICATION:**

A 11.10 Medicines acting on gastro-intestinal tract (Special combinations).

**PHARMACOLOGICAL ACTION:**

Laxative and digestive.

**INDICATIONS:**

Wonderkroonessens is an effective preparation for the treatment of constipation, winds and indigestion.

**CONTRA-INDICATIONS:**

Habitual use, undiagnosed abdominal pains, nausea and vomiting, and during pregnancy.

**DOSAGE AND DIRECTIONS FOR USE:**

Half to one medicine measureful (2.5-5 ml) in water morning and night, when necessary.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

As with all laxatives, continual use must be avoided. Large or overdoses may produce the following side-effects: griping, nausea, vomiting, excessive cathartic effects and gastro-intestinal irritation.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

See "Side-effects and Special Precautions". Use of the preparation must be discontinued.

**IDENTIFICATION:** Bright, dark brown liquid.**PRESENTATION:** 20 ml Packs.**STORAGE INSTRUCTIONS:**

Store below 25°C.

**KEEP OUT OF REACH OF CHILDREN.****APPLICATION NUMBER:** E1486 (Act/Wet 101/1965)**NAME AND BUSINESS ADDRESS OF APPLICANT:**

Lennon Limited

7 Fairclough Road

PORT ELIZABETH

6001

**Date of publication of this package insert:** 4.4.1985.

APPENDIX D  
MEDICINE BOXES OF *MUTI WENYONI* AND TRANSLATIONS

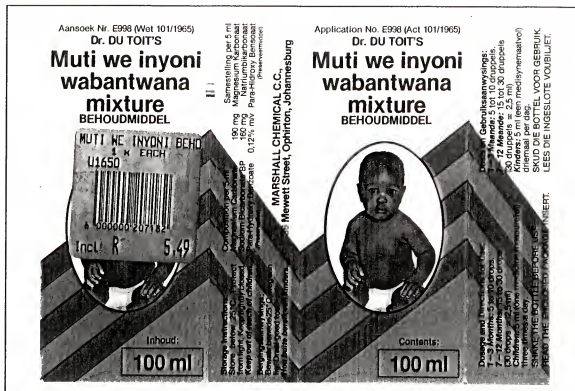


Figure 1 Dr. Du Toit's Muti we Inyoni Wabantwana Mixture

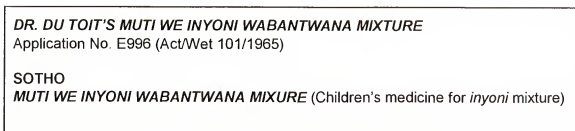


Figure 2 Dr. Du Toit's Muti we Inyoni Wabantwana Mixture Translation

**Intungwa Intungwa Intungwa Intungwa**  
**Intungwa Intungwa Intungwa Intungwa**

**UMUTHI WENYONI WABANTWANA**

Ref No. E639 (Wat 101/1965)  
 FLAKE 5 ml BEVAN

Kastorole	0,75 ml
Kadon Levis	70,1 mg
Bomutsakel	46,0 mg
Liq Tolu	0,094 ml
Chloroformspiritus	0,063 ml

HINI BUIFE BEYER VAN NIMHUIS

BERE OMTW 25°C

1/2 ZA I ABANTWANA LENYONI  
 Iyeka eliphandi okumanda  
 okugadim ezazu soga, urado  
 nenyoni (amandulo aluhaza) kusana  
 nasebantwani abancinci

100 ml  
 100 ml  
 100 ml

APPLICANT  
 RESMED PHARMACEUTICALS  
 40 PETER RD. SEA CLIFF LANE DURBAN

**MORIANA OA BANA OA NONYANE**

Ref No. E639 (Act 101/1965)  
 FLAKE 5 ml COM (NINE)

Caster Oil	0,75 ml
Kadon Levis	70,1 mg
Bomuthi Salicylate	46,0 mg
Liq Tolu	0,094 ml
Chloroform Spirit	0,063 ml

KEEP OUT OF REACH OF CHILDREN  
 STORE BELOW 25°C

**UMUTHI WENYONI WABANTWANA**  
 Umuthi ophambili okumanda  
 okungondisi isisu nenyoni, uhudo nenyoni  
 (amandulo aluhaza) kusana  
 nasebantwani abancinci

**MORIANA OA BANA OA NONYANE**  
 Mubusako o pole, o bethule ho emnyang  
 mako a bawakweni, letculu le mako a  
 mako masebenzi le bona

100 ml  
 100 ml  
 100 ml

APPLICANT  
 RESMED PHARMACEUTICALS  
 40 PETER RD. SEA CLIFF LANE DURBAN

Figure 3 Intungwa

**INTUNGWA** Ref. No. E639 (Act/Wet 101/1965)

**XHOSA**

**ITYEZA LABANTWANA LENYONI** (Children's medicine for *nyoni*)

*Iyeza eliphambili elinamandla ekugadeni isisu segazi, urudo nenyoni (amarudo aluhlaza) kusana nasebantwaneni abancinci.*

(A leading powerful medicine for infants, babies and small children to look after the stomach, bloody diarrhoea, diarrhoea, *nyoni* and green stools.)

**ZULU**

**UMUTHI WENYONI WABANTWANA** (Children's medicine for *nyoni*)

*Umuthi ophambili onamandla ekunqandeni isisu negazi, uhudo nenyoni (amahudo aluhlaza) kosana nasezinganeni ezincane.*

(A leading powerful medicine for the stomach and blood, diarrhoea and green diarrhoea for infants, babies and young children.)

**SESOTHO**

**MORIANA OA BANA OA NONYANE** (Medicine for children with *nyoni*)

*Motsoako o pele, obohale ho emiseng mala a tsoakileng, letsollo le mala a matala maseeng le bana.*

(This medicine is meant for stopping a "mixed up" stomach, diarrhoea and green stools of babies and infants.)

**AFRIKAANS** (on packaging insert)

*Tysono Brand Intungwa is bekend aan die Bantoe. Dit word gebruik vir die behandeling van disenterie en diarree. Hierdie ongesteldhede kom baie algemeen voor by babas en as die kondisie verwaarloos word, kan ernstige komplikasies intree.*

(Tysono Brand Intungwa is well-known by the Bantu. It is used in the treatment of dysentery and diarrhoea. This condition is very common amongst infants and if ignored very dangerous complications may set in.)

**ENGLISH** (on packaging insert)

Tysono Brand Intungwa is well-known by the Bantu. It is used in the treatment of dysentery and diarrhoea. This condition is very common amongst infants and if ignored very dangerous complications may set in.

**Figure 4** Intungwa Translation

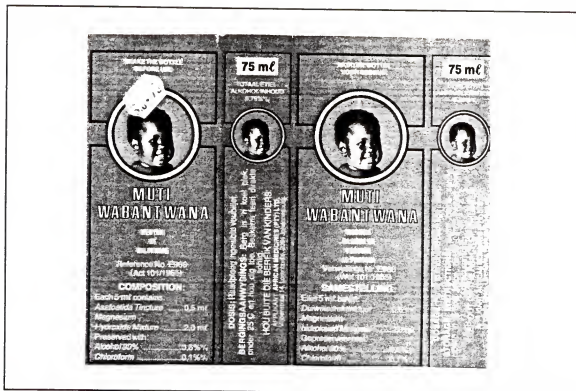


Figure 5 Muti Wabantwana

**MUTI WABANTWANA**

Ref. No. E966 (Act/Wet 101/1965)

**ZULU***Wenyoni ne Nhlokwane.* (For Wenyoni and Nhlokwane)**SESOHO***Moriana oa bana oa Kokoana le Phuoana.* (Medicine for children for Kokoana and Phuoana)**AFRIKAANS***Vir gebruik as 'n teensuur vir kleuters. Dit mag ook gebruik word om 'n sagte laksering op te lewer.* (For use as an antacid for infants. It may also be used to produce soft laxation.)**ENGLISH**

For use as an antacid for infants. It may also be used to produce mild laxation.

Figure 6 Muti Wabantwana Translation



Figure 7 Muti we Inyoni Wabantwana Mixture

MUTI WE INYONI WABANTWANA MIXTURE/MENGSEL E998 (Act 101/1965)

### ZULU

*We zingane nabantwana wokuqumbelana namahlaba* (For infants and children for constipation and pain)

### SESOOTHO

*Wa masea le bana o fedisa mahlaba le pipitlelo* (To heal the pain and constipation of infants and small children)

### AFRIKAANS

*Muti we inyoni, wabantwana is 'n teensuurmiddel vir koliek, krampe en winderigheid*

(Muti we inyoni, wabantwana is an antacid for colic, gripes and wind)

### ENGLISH

*Muti we inyoni, wabantwana is an antacid for infants and young children, for gripes colic and wind.*

Figure 8 Muti we Inyoni Wabantwana Mixture Translation



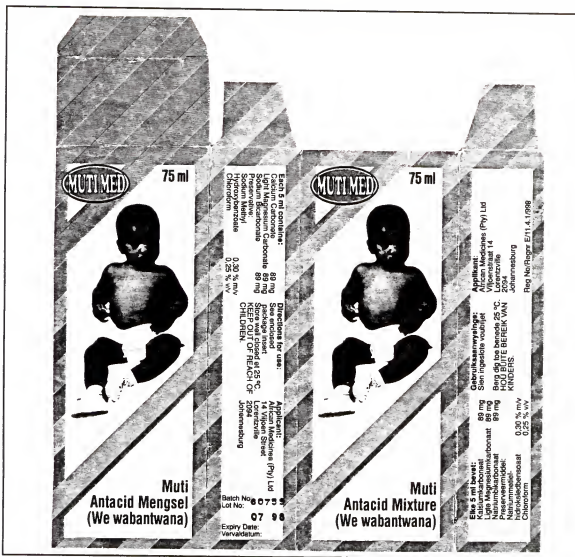


Figure 9 Muti Antacid Mixture (We Wabantwana)

**MUTI ANTACID MIXTURE (WE WABANTWANA)** Reg. No. E/11.4.1/998

**ENGLISH AND SOTHO:**

**Muti Antacid Mixture (We Wabantwana)** Antacid medicine mixture (for children)

**ENGLISH, AFRIKAANS AND SOTHO:**

**Muti Antacid Mengsel (We Wabantwana)** Antacid medicine mixture (for children)

Figure 10 Muti Antacid Mixture (We Wabantwana) Translation



**MUTHI WENYONI MIXTURE** Ref. No. E650 (Act/Wet 101/1965)

**ZULU**

**MUTHI WENYONI MIXTURE:**

**UMUTHI WENGANE** (This is children's medicine)

**WENYONI NENYAMAZANE** (*Wenyoni* and *nenyamazane* (direct); *nenyamazane* for *nyoni* or for the illness of *nenyamazane*)

**Yisifo esandile enganeni.** (It is a common illness in children). **Umtwana onenyanga<sup>1</sup>** (sic) **eziwu 2 (1/2 teaspoon).** (Babies under 2 months old (1/2 teaspoon)). **O-phezukwe nyanga eziwu 2 (1 teaspoon).** (Babies over 2 months old (1 teaspoon)). **Uphuziswa 3-4 ngelanga uma kunesidingo.** (Repeat when necessary 3-4 times daily). **Uyaziwa kakhulu kubantu ngegama elingenhla.** (It is known mostly by the above name). **Lokufa kubangwa ukungcola kwesisu, kwenza ingane ihude into eluhlaza.** (This illness is caused by a dirty stomach and causes the child to have green diarrhoea). **Uma iphuze lomuthi kuzophuma wonke ushevu izizwe ingcono kakhulu ibe namandla futhi.** (After taking this medicine, all the poison will come out and the child will feel much better and regain his/her energy/strength).

**SESOTHO**

**MUTHI WENYONI MENGSEL:**

**MORIANA OA BANA OA HLOHOANA** (Medicine for children with phwana)

**LETSHOLLO LE LETSHEHLA<sup>2</sup>** (sic) (Diarrhoea that is yellow)

**Phuana kelefutse leatlang<sup>3</sup>** (sic) **baneng.** (Phwana is an illness common to children).

**Bana bakatlase ho dikgwedi tse pedi (1/2 teaspoon).** (Babies under 2 months old (1/2 teaspoon)). **Ba kahodima dikgwedi tse pedi (1 teaspoon).** (Babies over 2 months old (1 teaspoon)). **O nswa bana 3-4 ka letsatsi ha ho hlokahala.**

(Repeat when necessary 3-4 times daily). **Moriana ona o tsejwa ka lebitso le ka hodimo.** (This medicine is known by the above name). **Hangata o thusa hontsha litshila maleng a ngoana a phele hantle a be lematla.** (In most cases it helps to take out the dirt in the child's stomach for the child to be healthy and have energy/strength.)

**AFRIKAANS**

**Muthi Wenyoni Mengsel is 'n teensuur aanbeveel vir kinders vir oormaat maagsuurheid en winderigheid.** (Muthi Wenyoni Mixture is an antacid recommended for infants for hyperacidity and flatulence.)

**Dosis: Babas onder 2 maande: 1/2 medisyne maat.** (Babies under 2 months: 1/2 medicine measure.) **Bo 2 maande: 1 medisyne maat.** (Over 2 months: 1 medicine measure.) **Herhaal soos nodig 3-4 maal daaglik.** (Repeat when necessary 3-4 times daily.)

**ENGLISH**

Muthi Wenyoni Mixture is an antacid recommended for infants for hyperacidity and flatulence.

**Dosage:** Babies under 2 months: 1/2 medicine measure. Over 2 months: 1

**Figure 12** Muthi Wenyoni Mixture Translation

**Muthi Wenyoni!**  
ANTACID MIXTURE  
Reg. No. N/11/11/1650

**Muthi Wenyoni Antacid Mengsel**  
Elke 5 ml bevat:  
Kalium-karbonaat ..... 87 mg  
Magnesium-karbonaat ..... 87 mg  
Natrium-bicarbonaat ..... 87 mg  
Natriumsteraat ..... 82 mg  
Totale alkohol ..... 3,739 % v/v  
Preservatiemiddel  
Methielparaben ..... 0,17 % v/v  
Propylparaben ..... 0,017 % v/v  
Bevat TARTRAZEN

Waar die gebruik van 'n teensuurmiddel aangedu word


**SKUD DEGLIK**

**DOSES** Kinders  
Onder 1 maand 2,5 ml  
1 - 12 maande 2,5 - 5 ml  
1 - 2 jaar 5 - 7,5 ml  
3 - 5 jaar 7,5 - 10 ml  
6 - 10 jaar 10 - 15 ml

Bewaar beneeds 30 °C in lugdigte toetre. Beskerm teen lig

**HOU BUTTE BEREIK VAN KINDERS**  
Bemark deur:  
Premier Consumer Division  
Purinsstraat 2, Isando, 1600

**Muthi Wenyoni ANTACID**



**LAPHO UKUBETSHENZISWA KOMUTHI OBABATO KUVEZIWE. KUKUZA KAHLE**

**ISILINGANISO** Iingane  
Alung'angano kwinyanga 2,5 ml, 1 - 12 izinyanga 2,5 - 5 ml, 1 - 2 iminyaka 5 - 7,5 ml, 3 - 5 iminyaka 7,5 - 10 ml, 6 - 10 iminyaka 10 - 15 ml.

Ugcine emleni: evaseka kahle nasezinyane kuzohlela ezingaphansi ku 30 °C. Wukhele ekukhanyeni.

**WUGCINE EKUDENI NEZINGANE**

The Premier Pharmaceutical Co. Ltd  
Esom Downs Office Park  
13 Steane St., Bryanston, 2152

**Muthi Wenyoni Antacid Mixture**  
Each 5 ml contains  
Calcium carbonate ..... 87 mg  
Magnesium carbonate ..... 87 mg  
Sodium bicarbonate ..... 87 mg  
Sodium stearate 82 mg  
Sodium citrate 62 mg  
Total alcohol ..... 3,739 % v/v  
Preservatives  
Methylparaben ..... 0,17 % v/v  
Propylparaben ..... 0,017 % v/v  
Contains TARTRAZINE

Where the use of an antacid is indicated


**SHAKE WELL**

**DOSAGE** Children  
Under 1 month 2,5 ml  
1 - 12 months 2,5 - 5 ml  
1 - 2 years 5 - 7,5 ml  
3 - 5 years 7,5 - 10 ml  
6 - 10 years 10 - 15 ml

Store below 30 °C in airtight containers. Protect from light

**KEEP OUT OF REACH OF CHILDREN**  
Marketed by  
Premier Consumer Division  
2 Purin Street, Isando, 1600

**Muthi Wenyoni ANTACID**



**MOO TSHBEDISO YA ANTACID E BONTSHITSWENG TENG. TSOKOTSA TEHANYETSO. BANA**

Ka tsala kwethi 2,5 ml, 1 - 12 dikwethi 2,5 - 5 ml, 1 - 2 diemo 5 - 7,5 ml, 3 - 5 diemo 7,5 - 10 ml, 6 - 10 diemo 10 - 15 ml

O Boleke moo ho leng ka tsala ho 30 °C ka sehlopheng se sa khatlelang moyi. Se ke wa o bota letshatso.

O BEHE MOO O SA PHILELWENG KE BANA

The Premier Pharmaceutical Co. Ltd  
Esom Downs Office Park  
Steane St., Bryanston, 2152

**75 ml**

**75 ml**

**75 ml**

**75 ml**

Figure 13 Muti Wenyoni Antacid Mixture

**MUTHI WENYONI ANTACID MIXTURE**

Reg. No./Nr. E/11.4.1/650

**ZULU****MUTHI WENYONI ANTACID:****LAPHO UKUSETSHENZISWA KOMUTI OBABAYO KUVEZIWE.** (Where the Use of An Antacid is Indicated)**XUKUZA KAHLE** (Shake Well)**ISILINGANISO:** *Izingane: Abangaphansi kwenyanga: 2,5ml; 1-12 Izinganga: 2,5-5ml; 1-2 Iminyaka: 5-7,5ml; 3-5 Iminyaka: 7,5-10ml; 6-10 Iminyaka: 10-15ml.*

(Dosage: Children: Under 1 month: 2,5ml; 1-12 months: 2,5-5ml; 1-2 years: 5-7,5ml; 3-5 years: 7,5-10ml; 6-10 years: 10-15ml)

**Ugcine entweni evaleke kahle nasezingeni lokushisa elingaphansi ku 30°C.**(Store below 30°C in airtight containers) **Wuvikele ekukhanyeni.** (Protect from light)**WUGCINE EKUDENI NEZINGANE.** (Keep Out of Reach of Children)**SESOTHO****MUTHI WENYONI ANTACID:****MOO TSHEBEDISO YA ANTACID E BONTSHITWENG TENG.** (Where the Use of An Antacid is Indicated). **Tsokotsa.** (Shake Well)**TEKANYESO:** *Bana: Ka tlasas kgwedi: 2,5ml; 1-12 dikgwedi: 2,5-5ml; 1-2 dilemo: 5-7,5ml; 3-5 dilemo: 7,5-10ml; 6-10 dilemo: 10-15ml.* (Dosage: Children:

Under 1 month: 2,5ml; 1-12 months: 2,5-5ml; 1-2 years: 5-7,5ml; 3-5 years: 7,5-10ml; 6-10 years: 10-15ml)

**O Boloke moo ho leng ka tlase ho 30 °C. Ka setshelong se sa kaneleng moya.**(Store below 30°C in airtight containers) **Se ke wa o beha letsatsing.** (Protect from light)**O BEHE MOO O SA FIHLELLWENG KE BANA.** (Keep Out of Reach of Children)**AFRIKAANS****MUTI WENYONI ANTACID MENGSEL** (Muti Wenyoni Antacid Mixture)**Waar die gebruik van 'n teensuurmiddel aangedui word.** (Where the use of an antacid is indicated) **SKUD DEEGLIK.** (Shake Well)**DOSIS: Kinders: Onder 1 maand: 2,5 ml; 1-12 maande: 2,5-5ml; 1-2 jaar: 5-7,5ml; 3-5 jaar: 7,5-10ml; 6-10 jaar: 10-15ml.** (Dosage: Children: Under 1 month: 2,5ml; 1-12 months: 2,5-5ml; 1-2 years: 5-7,5ml; 3-5 years: 7,5-10ml; 6-10 years: 10-15ml)**Bewaar benede 30 °C in lugdigte houers.** (Store below 30 °C in airtight containers)**Beskerm teen lig.** (Protect from light)**HOU BUIE BEREIK VAN KINDERS.** (Keep Out of Reach of Children)**ENGLISH****MUTI WENYONI ANTACID MIXTURE**Where the use of an antacid is indicated. **SHAKE WELL.****DOSAGE:** Children: Under 1 month: 2,5ml; 1-12 months: 2,5-5ml; 1-2 years: 5-7,5ml; 3-5 years: 7,5-10ml; 6-10 years: 10-15ml. Store below 30 °C in airtight containers. Protect from light. **KEEP OUT OF REACH OF CHILDREN.****Figure 14** Muti Wenyoni Antacid Mixture Translation



Figure 15 Wills Infant Diarrhoea Mixture

**WILLS INFANTS DIARRHOEA MIXTURE**

Ref. No. E1261 (Act/Wet

101/1965)

**WILLS DIARRHEEMENGSEL VIR KINDERS****ENGLISH/AFRIKAANS****Umuthi Wenyoni Wabantwana Suspension Suspensie****ZULU****Iyeza Labantwana Lenyoni Nenyamazane Ishshaza**(Medicine for children with *Inyoni*, *Nenyamazane* and rash)**TSWANA****Setlhare Sa Bana Sa Nonyane Le Mala A Matala**(Medicine for children with *Inyoni* and strong stomach pain)**SESOTHO****Moriana Oa Bana Oa Nonyane Le Mala A Matla**(Medicine for children with *Inyoni* and strong stomach pain).

Figure 16 Wills Infant Diarrhoea Mixture Translation

APPENDIX E  
PACKAGE INSERTS OF *MUTI WENYONI*

**DR. DU TOIT'S MUTI WE INYONI WABANTWANA MIXTURE (BEHOUDMIDDEL)**  
[Dr. Du Toit's Medicine for *Inyoni* for children mixture (protective medicine)]

**SCHEDULING STATUS:** Unscheduled (O/U)

**PROPRIETARY NAME:** DR. DU TOIT'S BEHOUDMIDDEL

**COMPOSITION:** Per 5 ml:

Magnesium Carbonate Light	190 mg
Sodium Bicarbonate BP	160 mg
Methyl-P-Hydroxybenzoate	0.12% w/v
(Preservative)	

**PHARMACOLOGICAL CLASSIFICATION:** 11.4

**PHARMACOLOGICAL ACTION:** Acts by neutralising stomach acid by acid alkali chemical reaction. Indirectly suppresses peptic activity and elevates the pH balance of the gastric content which induces the pyloric antrum to release gastrin causing increased gastric motility and lowered sphincter pressure.

**INDICATIONS:** For infants and young children. Use for colic and griping, for irritability caused by wind and colic in infants. Use also for diarrhoea.

**CONTRA-INDICATIONS:** In case of serious renal insufficiency.

**WARNINGS:** Do not use for longer than 10 days. Keep out of reach of children. Always use all medicines with caution when treating infants.

**DOSAGE AND DIRECTIONS FOR USE:** 1-3 months: 5 to 10 drops, 7-12 months: 15 to 30 drops, (30 drops = 2.5 ml). Children: 5 ml (one medicine measureful) three times a day.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:** Uncommon. Discontinue use if any ill effects noted. Belching and constipation. Do not use for long continuous periods.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:** Constipation and increased urine excretion. Electrolytic imbalance. Consult a doctor immediately, especially in the case of infants. Treatment is symptomatic.

**IDENTIFICATION:** Light brown liquid suspension with white sediment on standing and having an odour of aniseed and sweet taste.

**PRESENTATION:** In 100 ml PVC bottles with plastic cap.

**STORAGE INSTRUCTIONS:** Store below 25°C protected from light. Keep tightly closed.

**REGISTRATION NUMBER:** APPL.NO: E998 (Act 101/1965)

**NAME AND ADDRESS OF APPLICANT:**

MARSHALL CHEMICAL CO. (PTY) LTD.

36 Mewett Street

Ophirton

Johannesburg.

**Date of publication of insert:** 16/10/85.

**TYSONO BRAND INTUNGWA****SCHEDULING STATUS: S2****PROPRIETARY NAME (AND DOSAGE FORM): TYSONO BRAND INTUNGWA (Emulsion).****COMPOSITION:**

Each 5 ml contains:

Castor Oil	0.75 ml
Kaolin Levis	78.1 mg
Bismuth Salicylate	46.9 mg
Liq. Tolu	0.094 ml
Chloroform Spirit	0.063 ml

Contains 4.2% Alcohol

Preserved with Methyl Hydroxy Benzoate 0.05% m/v &amp; Sodium Benzoate 0.1% m/v

**PHARMACOLOGICAL CLASSIFICATION:**

Category A: Classification 11.9 (Anti-Diarrhoeals)

**PHARMACOLOGICAL ACTION:** Tysono Brand Intungwa absorbs toxic substances from the Alimentary Tract and increases the bulk of the faeces. This preparation is also taken for its protective and antacid action. This preparation also has a protective action on mucous membranes and raw surfaces and is known for its weakly astringent properties.**INDICATIONS:** Tysono Brand Intungwa is well-known by the Bantu. It is used in the treatment of dysentery and diarrhoea. This condition is very common amongst infants and if ignored very dangerous complications may set in.**CONTRA-INDICATIONS:** Contra-indicated in Renal insufficiency.**DOSAGE AND DIRECTIONS FOR USE:**

Under 3 months: half x 5 ml dose, twice a day.

3 - 6 months: Half x 5 ml dose three times a day.

6 months and over: one 5 ml dose three times a day.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:** None known.**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

The effect of acute bismuth intoxication include gastro-intestinal disturbance, anorexia, headache, malaise, skin reactions, discoloration of mucous membranes and mild jaundice. A blue line on the gum, the 'bismuth line', may persist for years if albuminuria or stomatitis occurs. Bismuth should be immediately withdrawn as serious ulcerative stomatitis or renal failure may result. Severe bismuth intoxication may be treated with dimercaprol. The excretion of bismuth may be assisted by acidification of the urine with ammonium chloride.

**IDENTIFICATION:** A white emulsion.**PRESENTATION:** In bottles of 50 ml and 100 ml each.**STORAGE INSTRUCTIONS:** Store in a cool place (under 30°C) and out of reach of children.**REGISTRATION NUMBER ( or Reference Number):** E839 (Act 101/1965).**APPLICANT:**

RESMED PHARMACEUTICALS

40 Peter Rd

Sea Cow Lake

DURBAN

**Date of Publication:** 14/3/85.



**MUTI WABANTWANA (Suspension)****SCHEDULING STATUS:** Unscheduled**PROPRIETARY NAME:** Muti Wabantwana (Suspension)**COMPOSITION:** Each 5 ml contains:

Asafoetida Tincture	0.5 ml
Magnesium Hydroxide Mixture	2.0 ml
Preserved with:	
Alcohol (90%)	0.6% v/v
Chloroform	0.1% v/v
Total ethyl alcohol content	6.79% v/v

**PHARMACOLOGICAL CLASSIFICATION:** A 11.4 (Antacids)**INDICATIONS:**

For use as an antacid for infants. It may also be used to produce mild laxation.

**CONTRA-INDICATIONS:** Severe renal insufficiency.**WARNINGS:** Do not exceed the stated dosage.**DOSAGE AND DIRECTIONS FOR USE:**

Infants: One month: 10 drops (0.6 ml), 2-6 months: 15 drops (1.0 ml), 7-12 months: Half a medicine measure (2.5 ml), Over one year: One medicine measure (5.0 ml), Repeat twice daily morning and evening.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

Muti Wabantwana has laxative side-effects and may cause diarrhoea. The absorption of other medicines e.g. tetracyclines taken concomitantly with Muti Wabantwana, may be impaired.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Excessive laxation may indicate overdosage. Overdosage may precipitate hypermagnesaemia characterised by flushing of the skin, thirst, hypotension, drowsiness and muscular weakness. This may be corrected by the intravenous injection of 10 to 20 ml Calcium Gluconate injection.

**CONDITIONS OF REGISTRATION:** None.**IDENTIFICATION:**

A straw-coloured suspension with an acrid, garlic-like odour which, upon standing forms a white sediment and a pale yellow supernatant liquid.

**PRESENTATION:** 50 ml, 75 ml, and 100 ml clear PVC bottles.**STORAGE INSTRUCTIONS:** Store bottle tightly closed in a cool place (below 25°C).

Protect from direct sunlight. Keep out of reach of children.

**REFERENCE NUMBER:** E 966 (Wet/Act 101/1965)**APPLICANT:**

African Medicines (Pty) Ltd

14 Viljoen Street

Lorentzville

Johannesburg

2094

**Date of publication:** 11 September 1972.

**MUTHI WENYONI MIXTURE****SCHEDULING STATUS:** Not scheduled**PROPRIETARY NAME** (and dosage form): **MUTHI WENYONI MIXTURE****COMPOSITION:** Each 5 ml contains:

Calcium Carbonate	87 mg
Magnesium Carbonate	87 mg
Sodium Bicarbonate	87 mg
Sodium Citrate	62 mg
Chloroform Spirit	0.125 ml
Tincture Asafoetida	0.08 ml
Concentrated Dill Water	0.062 ml
Total Alcohol	3.739% v/v
Preservatives:	
Methylparaben	0.17% m/v
Propylparaben	0.017% m/v
Total Chloroform	0.225% v/v
Contains TARTRAZINE	

**PHARMACOLOGICAL CLASSIFICATION:** A 11.4.3 Medicines acting on gastro-intestinal tract. Other.**PHARMACOLOGICAL ACTION:** Antacid.**INDICATIONS:** Hyperacidity and flatulence.**CONTRA-INDICATIONS:**

Impaired renal function, cardiac failure, hypertension, peripheral and pulmonary oedema. Concomitant administration of tetracyclines.

**WARNING:**

Contains tartrazine which may cause allergic type reactions (including bronchial asthma) in certain individuals. The overall incidence of tartrazine sensitivity is low; it is however frequently seen in patients who also have aspirin sensitivity.

**DOSAGE AND DIRECTIONS FOR USE:**

Babies under 2 months old: ½ medicine measure (2.5 ml). Repeat when necessary 3-4 times daily. Babies over 2 months old: 1 medicine measure (5 ml). Repeat when necessary 3-4 times daily.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

Hypercalcaemia may occur and the symptoms include anorexia, nausea, vomiting, constipation, abdominal pain, muscle weakness, thirst, polyuria, drowsiness, confusion, bone pain due to demineralisation, nephrocalcinosis, loss of renal concentrating capacity, renal calculi, and in severe cases, cardiac arrhythmias, coma and cardiac arrest. The release of carbon dioxide in the stomach may cause discomfort. Diarrhoea, mucosal irritation and absorption of magnesium may occur if there is gastro-intestinal atony or obstruction. If renal function is impaired hypermagnesaemia may occur. The symptoms include flushing of the skin, thirst, hypotension due to vasodilation, drowsiness, loss of tendon reflexes due to neuromuscular blockade, weakness, respiratory depression, cardiac arrhythmias, coma and cardiac arrest. Hypernatraemia may also occur and the symptoms include restlessness, weakness, thirst, reduced salivation and lachrymation, swollen tongue, flushing of the skin, pyrexia, dizziness, headache, oliguria, hypotension, tachycardia, delirium, hyperpnoea and respiratory arrest.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

As under side-effects. Treatment is symptomatic and supportive. Consult your doctor or take the patient to the nearest hospital.

**IDENTIFICATION:** A beige suspension with an odour of asafoetida.

**PRESENTATION:** 75 ml and 100 ml packed in plastic bottles.

**STORAGE INSTRUCTIONS:**

Store below 30°C in airtight containers and protect from light. Keep out of reach of children.

**REFERENCE NUMBER:** E650 (Act 101/1965).

**NAME AND BUSINESS ADDRESS OF THE APPLICANT:**

Twins Pharmaceuticals Limited  
Cnr Isando Road and Purlin Street  
Isando

**Date of publication of this package insert:** 1972.

**MUTHI WENYONI ANTACID MIXTURE COMPOSITION****SCHEDULING STATUS:** Not scheduled.**PROPRIETARY NAME (and dosage form):** MUTHI WENYONI ANTACID MIXTURE  
**COMPOSITION:**

Each 5 ml contains:

Calcium carbonate	87 mg
Magnesium carbonate	87 mg
Sodium bicarbonate	87 mg
Sodium citrate	62 mg
Total alcohol	3.739% v/v
Preservatives:	
Methylparaben	0.17% m/v
Propylparaben	0.017% m/v
Contains TARTRAZINE	

**PHARMACOLOGICAL CLASSIFICATION:** A 11.4.1 Antacids - Acid neutralizers.**PHARMACOLOGICAL ACTION:** Antacid, with the capability of neutralizing the acid in the stomach.**INDICATIONS:** Where the use of an antacid is indicated.**CONTRA-INDICATIONS:** Sensitivity to any of the ingredients. It should not be administered to patients with metabolic or respiratory alkalosis, hypocalcaemia, or hypochlorhydria.**WARNINGS:** Contains 19.5 mg and 39 mg of sodium in ½ and 1 medicine measureful respectively. Do not use this product if you are on a sodium restricted diet, or suffer from hypertension, or heart failure, except under the supervision of a doctor. Use with care in patients with renal failure. May enhance the cardiac effects of digitalis glycosides. Contains tartrazine which may cause allergic type reactions (including bronchial asthma) in certain susceptible individuals. The overall incidence of tartrazine sensitivity is low; it is however frequently seen in patients who also have aspirin sensitivity.**DOSAGE AND DIRECTIONS FOR USE:** The following dosage may be given not more than three to four times per 24 hour period.**Children:**

Under 1 month:	½ medicine measure (2.5 ml).
1 - 12 months:	½ - 1 medicine measure (2.5 - 5 ml)
1 - 2 years:	1 - 1½ medicine measures (5 - 7.5 ml)
3 - 5 years:	1½ - 2 medicine measures (7.5 - 10 ml)
6 - 10 years:	2 - 3 medicine measures (10 - 15 ml)

**DO NOT GIVE THIS MEDICINE TO BABIES WITH A BODY MASS LESS THAN 2.5 KG.**

Do not use the maximum daily dosage of this product for more than 2 weeks, except under the advice and supervision of a doctor.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:**

Calcium carbonate may cause constipation. Flatulence from released carbon dioxide is not usually a serious problem though eructation may occur in some patients. Hypercalcaemia and alkalosis can occur following regular use of calcium carbonate; the milk-alkali syndrome which includes both features together with renal dysfunction has occurred, usually in patients taking high doses. Magnesium carbonate may cause diarrhoea. The release of carbon dioxide in the stomach may cause discomfort. If renal function is impaired, hypermagnesaemia may result. The symptoms include flushing of the skin, thirst,

hypotension due to peripheral vasodilatation, drowsiness, confusion, loss of tendon reflexes due to neuromuscular blockade, muscle weakness, respiratory depression, cardiac arrhythmias, coma, and cardiac arrest. May interfere with the absorption of other medicines given concomitantly. Sodium bicarbonate may cause stomach cramps and flatulence. Excessive administration of sodium bicarbonate may lead to metabolic alkalosis, especially in patients with impaired renal function. Symptoms may include shortness of breath, muscle weakness (associated with potassium depletion), and mental disturbances such as restlessness, convulsions, and coma. Muscle hypertonicity, twitching, and tetany may develop especially in hypocalcaemic patients due to increased protein binding and renal reabsorption of calcium. Excessive doses may also lead to sodium overloading and hyperosmolality. Symptoms include nausea, vomiting, diarrhoea, abdominal cramps, thirst, reduced salivation and lachrymation, sweating, fever, hypotension, tachycardia, renal failure, peripheral and pulmonary oedema, respiratory arrest, headache, dizziness, restlessness, irritability, weakness, muscular twitching and rigidity, convulsions, coma, and death. Infants may appear not to be severely dehydrated, but coma and convulsions may persist due to vascular injury. They may show respiratory distress with tachypnoea and flaring nostrils. Sodium bicarbonate should be administered with extreme caution to patients with congestive heart failure, renal impairment, cirrhosis of the liver, or hypertension, and to patients receiving corticosteroids. Alkalinisation of the urine by sodium bicarbonate leads to increased renal clearance of acidic drugs.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

As under "Side-effects and Special Precautions". Treatment consists of appropriate correction of fluid and electrolyte balance. Further treatment is symptomatic and supportive. Consult your doctor or take the patient to the nearest hospital immediately.

**IDENTIFICATION:** A beige suspension with an odour of asafoetida.

**PRESENTATION:** 75 ml and 100 ml packed in clear PVC bottles.

**STORAGE INSTRUCTIONS:**

Store below 30°C in airtight containers and protect from light.

**KEEP OUT OF REACH OF CHILDREN.**

**REGISTRATION NUMBER:** E/11.4.1/650

**NAME AND BUSINESS ADDRESS OF APPLICANT:**

The Premier Pharmaceutical Company Limited  
Epsom Downs Office Park  
13 Sloane Street  
Bryanston 2152

**MARKETED BY:**

Premier Consumer Division  
2 Purlin Street  
Isando 1600

**Date of publication of this package insert:** 09/11/1994.

**MUTI WE INYONI WABANTWANA (Mixture)****SCHEDULING STATUS:** Not Scheduled.**PROPRIETARY NAME:** MUTI WE INYONI WABANTWANA (Mixture)**COMPOSITION:** Each 5 ml contains:

Calcium Carbonate	89 mg
Light Magnesium Carbonate	89 mg
Sodium Bicarbonate	89 mg
Chloroform (Preservative)	0.25% v/v

**PHARMACOLOGICAL CLASSIFICATION:** 11.4 Antacids.**PHARMACOLOGICAL ACTION:**

Calcium Carbonate and Sodium Bicarbonate both act as antacids and Magnesium Carbonate as mild laxative.

**INDICATIONS:**

For irritability in infants caused by wind, colic, griping and diarrhoea.

**CONTRA-INDICATIONS:** Should not be used by patients with impaired renal function.**WARNINGS:** Always use all medicines with caution when treating infants. Do not use with large quantities of milk or cream. Do not use doses in excess of those recommended and over long periods.**DOSAGE AND DIRECTIONS FOR USE:**

Babies 1-3 months: 5-10 drops (1 ml) 3-4 times a day. Babies 4-12 months: 15-30 drops (2.5 ml) 3-4 times a day. Older children: One 5 ml medicine measure 3-4 times a day.

**SIDE-EFFECTS:**

Constipation or diarrhoea may occur in some persons. Milk-alkali syndrome may develop if used with large quantities of milk or cream.

**SPECIAL PRECAUTIONS:**

Do not use concomitantly with tetracyclines, digoxin and oral iron preparations, as the absorption of these drugs may be diminished.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

Hypercalcaemia, alkalon and milk-alkali syndrome may occur with large doses. With renal impairment, hypermagnesaemia may occur, as well as congestive cardiac failure due to excessive sodium absorption and symptoms of hypernatraemia and hyponatraemia. If overdosage is suspected, consult a doctor immediately, especially in the case of infants.

**IDENTIFICATION:**

Off-white to beige mixture with sediment, having the odour of asafetida, and a sweet and chalky taste with the asafetida characteristic taste.

**PRESENTATION:** 50 ml, 75 ml, 100 ml and 200 ml bottles available.**STORAGE INSTRUCTIONS:**

Keep well closed out of direct sunlight. Keep out of reach of children.

**REFERENCE NUMBER:** E998 (Act 101/1965).**NAME AND BUSINESS ADDRESS OF THE APPLICANT:**

S.G. TOMSETT

c/o Muti Medicines

201 Commissioner Street

Johannesburg

**Date of Publication of this package insert:** 1972.

**MUTI ANTACID MIXTURE****SCHEDULING STATUS:** Not scheduled.**PROPRIETARY NAME:** MUTI ANTACID MIXTURE**COMPOSITION:** Each 5 ml contains:

Calcium Carbonate	89 mg
Light Magnesium Carbonate	89 mg
Sodium Bicarbonate	89 mg
Preserved with:	
Sodium Methyl Hydroxybenzoate	0.30% m/v
Chloroform	0.25% v/v

**PHARMACOLOGICAL CLASSIFICATION:** A 11.4.1 (Antacids-Acid Neutralisers)**PHARMACOLOGICAL ACTION:** Acid neutralising.**INDICATIONS:** Where an antacid is indicated.**CONTRA-INDICATIONS:** Should not be used in patients with impaired renal function.**WARNINGS:** May interfere with the absorption of other medicines given concomitantly.**DOSAGE AND DIRECTIONS FOR USE:**

Babies under 1 month:	3 ml three times a day
Babies 1-6 months:	4 ml three times a day
6 months to 1 year:	5 ml three times a day
1 - 2 years:	6 ml three times a day
3 - 5 years:	8 ml three times a day
6 - 10 years:	12 ml three times a day

or as prescribed by your doctor. Do not exceed the stated dose. Do not give this medicine to babies with a body mass of less than 2.5 kg.

**SIDE-EFFECTS AND SPECIAL PRECAUTIONS:** Flatulence from release of carbon dioxide may cause some abdominal discomfort, eruptions may occur in some patients. Hypercalcaemia and alkalosis can occur following regular use of calcium carbonate. Milk-alkali syndrome has occurred usually in patients taking high doses. Hypermagnesaemia may occur if renal function is impaired. Excessive doses may lead to hypernatraemia.

**KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT:**

See side-effects. Treatment is supportive and symptomatic.

**IDENTIFICATION:** Off-white to beige mixture with sediment, having the odour of asafoetida, and a sweet chalky taste with the characteristic asafoetida taste.

**PRESENTATION:** Colourless plastic bottle with a white plastic cap available in 75 ml bottles, with a 5 ml plastic measuring cup.

**STORAGE INSTRUCTIONS:** Store well closed at room temperature (25°C).

**KEEP OUT OF REACH OF CHILDREN.****REGISTRATION NUMBER:** E/11.4.1/998**NAME AND BUSINESS ADDRESS OF THE APPLICANT:**

African Medicines (Pty) Ltd  
14 Viljoen Street  
Lorentzville 2094  
Johannesburg

**Date of publication of this package insert:** 19 May 1995.

## GLOSSARY

Abathakhathi	Witches
Baloi	Witches
Boer	Farmer, equivalent of the pioneers who moved West
Deurmekaargood	Reference to the mixture of medicines
Didruppels	Dutch medicines
Distuip	Dutch medicines
Ditlare tsa Sekgoa	Medicine of White culture.
Ditlare tsa Sesotho	Medicine of African culture
Ditlare tsa Setho	Medicine of African culture.
Druppels	Drops
Emibi	Harmful or bad
Emoya	Spirits
Gabola	Inhaling
Gatega	Suppressed
Getrap	Stepped upon or stomped on
Huis-apotheek	Home medicine chest
Hollandse medisyne	Dutch medicine
Huismiddel	Home remedy
Imbiza	A collective term for purgatives usually associated with internal cleansing



Imimoya	"Tracks" floating in the air.
Inyoni	Literally means bird. Is explained as a life threatening condition where a "snake" or a "worm" is eating the child's "insides". Green stools are also associated with this condition. If untreated, <i>inyoni</i> leads to a sunken fontanelle and ultimately the child's death.
Isihlambezo	A herbal extraction or modern concoction to encourage a problem free pregnancy and speedy delivery.
Izinyamazane	Wild animal poisons.
Kokwana	Referring to the illness caused by a small snake or worm leading to a sunken fontanel
Khujwana	Umbilical cord.
Modruga	Drug
Muti	Medicine.
Phugwana	Literally fontanel, but also referring to the illness of the fontanel.
Platteland	Country districts in South Africa.
Spaza	Small informal neighbourhood shops , usually a room in a house, a garage or a small room next to the house.
Stuipe	Fits.
Trekboeren	Trek farmers.
Trommel	Trunk usually metal.
Uhabula	Inhale.
Ukhakhae	Literally fontanel, but also referring to the illness of the fontanel.
Umkhondo	The Zulu word usually refers to visible tracks or spoor on the ground but can also be a reference to invisible tracks like what dogs can detect. <i>Mohlala</i> in Sotho.
Umuthi	Medicine.

Yard

A yard is a piece of enclosed or clearly marked ground with one or more structures on it. The space is shared by one or more households.

Zabantwana

For children.

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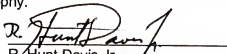
## BIOGRAPHICAL SKETCH

Thea de Wet attended the University of the Free State, South Africa, where she received a Bachelor of Arts with honours in anthropology, and a Masters of Arts degree in anthropology. Her master's thesis explored the nutritional status of children in Botshabelo, Free State Province. She also holds a Diploma in Higher Education from the same university. Ms. de Wet is currently employed by the Medical Research Council of South Africa and is the project manager of Birth to Ten, a longitudinal birth cohort study, running from 1990 to 2000 in the Soweto-Johannesburg metropolitan area.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

  
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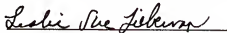
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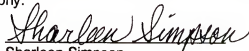
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